BARRANCA OPTOMETRY
4250 Barranca Parkway, Suite J
Irvine, CA 92604

Dr. Raymond Huang, O.D.
1409 S. Monterey Street
Alhambra, CA 91801

Welcome to our office!

Date_____

Name: _____ Spouse: _____
Last First MI

Address: _____
City State Zip

Home #: _____ Work/Cell #: _____ Email: _____

Birthday _____/_____/_____ Age _____ Sex _____ Occupation _____

Vision Insurance ID/SSN _____-_____-_____ Employer _____

If the patient is a dependent, name of parent/guardian responsible for the account.

Name: _____ Relationship to patient: _____

Date of last eye exam: _____ By whom? _____

Are you having problems seeing:

In the distance? □Y □N with glasses? □
Up close/reading □Y □N contacts? □
At computers? □Y □N or both? □

If you wear contacts, what brand/type do you use? RGP □ Soft □ Brand: _____

Have you or your family members ever been diagnosed with any of the following conditions?

	Yourself	Family	If a family member, what is the relationship?
High blood pressure	□Y □N	□Y □N	_____
Diabetes	□Y □N	□Y □N	_____
Thyroid disorder	□Y □N	□Y □N	_____
Heart disease	□Y □N	□Y □N	_____
High cholesterol	□Y □N	□Y □N	_____
Cancer (type_____)	□Y □N	□Y □N	_____
Glaucoma	□Y □N	□Y □N	_____
Macular degeneration (ARMD)	□Y □N	□Y □N	_____
Lazy eye (Amblyopia)	□Y □N	□Y □N	_____
Eye turn (Strabismus)	□Y □N	□Y □N	_____

Date of last physical exam: _____ By whom?_____
Do you currently take any medications? □Y □N If yes, please list _____
Are you allergic to any medication? □Y □N If yes, which ones? _____
Any other known allergies? □Y □N If yes, to what? _____
Have you had eye surgery? □Y □N If yes, what kind and when? _____

I authorize the release of medical information necessary to provide the most beneficial/complete visual examination. I understand that I am financially responsible for all charges whether or not paid for by insurance. Payment is due at the time services are rendered. Thank you!

_____
Signature of patient or responsible party

CONTACT LENS PATIENT: Your success with contact lens depends upon follow-up cares. We would like to see you after one week of wearing your new diagnostic lenses. There is no charge for this follow-up visit. It is your responsibility to schedule and keep this appointment. Furthermore, contact lenses are medical devices. It can cause serious eye problems without proper care and routine follow-up. Therefore**, OUR OFFICE CANNOT RELEASE YOUR CONTACT LENS PRESCRIPTION WITHOUT FINALIZING YOUR CONTACT LENS EXAM WHICH INCLUDES THE FOLLOW- UP VISIT AT THE DOCTOR'S DISCRETION.**
Please sign below to indicate your understanding of our office policy. Thank you!

_____
Signature of patient or responsible party