DR. GILBERT G. WONG
OPTOMETRIST

Clear Vision Begins With Healthy Eyes

Date: _____

PATIENT INFORMATION

Last name _____ First Name _____MI ____

D.O.B _____ Age _____ SS# _____

Address _____ Employer _____

City _____State _____ Zip _____ Occupation _____

Home Phone _____ Marital Status: Single_____ Married _____

Day Time Phone _____ Divorced ___Widowed ____ Domestic Partner ___

Cell Phone _____ **In case of emergency**

E-mail _____ Name _____

Referred by _____ Phone # _____

Relationship _____

Insurance

Vision **Medical**

Insurance Co: _____ Insurance Co: _____

ID# _____ ID _____Group# _____

Primary Account Holder Primary Account Holder

Self ___ Other: _____ Self ___ Other: _____

Name/D.O.B. Name/D.O.B.

ASSIGNMENT AND RELEASE

I assign directly to Gilbert G. Wong all insurance benefits for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date: _____

I request that any payment of authorized Medicare benefits be made on my behalf to Dr. Gilbert G. Wong for any services furnished me by that doctor. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____ Date _____

Eye Health

What is the main reason for coming in today?

_____

_____

Last Eye exam _____

Do you wear glasses? Yes No All the time _____
Occasionally___ Reading ___ Driving ___ TV ___

Do you wear contacts? Yes No Type _____

Have you had any eye surgery?

Cataract ___ RK ___ Lasik ___ Other_____

Are you currently experiencing any of the following with your eyes?

Blurred vision ___ Flashes ___ Burning ___ Floaters ___
Discharge ___ Itching ___

Double Vision ___ Redness ___ Dry Eye ___ Vision loss ___
Eye Strain ___ Other_____

Have you or a family member been diagnosed with any of the following?

Cataracts	YES/NO	Who _____	Allergy	YES/NO	Who _____
Glaucoma	YES/NO	Who _____	Immunologic	YES/NO	Who _____
Macular Degeneration	YES/NO	Who _____	Cardiovascular	YES/NO	Who _____
Other eye conditions	YES/NO	Who _____	Integumentary/Skin	YES/NO	Who _____
Diabetes	YES/NO	Who _____	Ears, nose, mouth, throat	YES/NO	Who _____
High Blood Pressure	YES/NO	Who _____	Musculoskeletal	YES/NO	Who _____
High Cholesterol	YES/NO	Who _____	Endocrine	YES/NO	Who _____
Rheumatoid Arthritis	YES/NO	Who _____	Neurologic	YES/NO	Who _____
Thyroid Problems	YES/NO	Who _____			

Name of Primary Care Physician _____ **Phone #** _____

MEDICATION

Please list any medication you are currently taking and what they are for

_____ _____ _____

_____ _____ _____

Do you have allergies to any medication YES/NO Which? _____ Reactions _____

AFFORDABLE CARE ACT REQUIREMENTS

Communication Preference Email Postal Telephone Height _____Weight _____ Race _____

Ethnicity _____Preferred Language _____

Alcohol Use? YES/NO X a week_____ Tobacco use YES/NO X a week _____

Recreational drugs YES/NO x a week _____ Females, are you currently pregnant or nursing? YES/NO

Dr. Gilbert G. Wong Optometrist is not responsible for previously used frames and/or lenses which are being reused or adjusted at my request. Eyeglass lenses and frames are non-returnable and non-refundable medical devices. Eyeglass frames are warranted only for manufacturer's defects one time within one year of purchase; shipping, handling and restocking fees will apply. Prescription accuracy is warranted and must be reported within 30 days from date of exam with one time redo of lenses purchased here. Unmarked and unopened contact lens boxes may be exchanged within 30 days from date of exam; a restocking fee will apply. Contact lens fittings are non-refundable.

Signature _____ Date _____