Q Vision

Personal Information

First Name ____ M.I. ____ Last Name ____

☐ M ☐ F — **Gender** ____ / / **Date of Birth** ____ **Age** ____

Address ____

City ____ State ____ Zip ____

Occupation ____

Contact Information

Home Number ____

Work Number ____

Mobile Number ____

Email Address ____

Referral Information

☐ **Internet** *Website, Search Engines...*

☐ **Yellowpages** *Business listings*

☐ **Insurance** *Providers website, phone, etc.*

☐ **Signs** *Billboards, street signs...*

☐ **Print** *Postcards, Flyers, Newspapers...*

☐ **Word of Mouth** *Friends, family, other*

☐ **Walk-In** *No Prior Knowledge*

☐ **Other** ____

Visit Information

Type of Visit ☐ **Spectacle Exam** ☐ **Contact Lens Exam** ☐ **Office Visit**

Vision Insurance ☐ **Yes** ☐ **No**

Personal History

Date of Last Exam ____

Previous Doctor ____

Medications you're taking ____

Medications allergic to ____

Check any conditions that apply to you or an immediate family member

	You	Family Member		You	Family Member
Diabetes	☐	☐	**Glaucoma**	☐	☐
Heart Disease	☐	☐	**Lazy Eye**	☐	☐
Headaches	☐	☐	**Eye Surgery**	☐	☐
High Blood Pressure	☐	☐			

Other Important Information About Your Eyes ____

Have you ever worn glasses ☐ *Yes* ☐ *No*

Have you ever worn contacts ☐ *Yes* ☐ *No*

Do you currently wear contacts ☐ *Yes* ☐ *No*

Dilation Information

Dilation is the use of drops to temporarily enlarge the pupil. It allows the doctor to better look for things such as retinal holes, detachments, tumors, signs of high blood pressure, diabetes, and glaucoma that can be otherwise missed. Dilation takes an additional 20-30 minutes. ***There is an additional charge of $20.00 for this service.*** ☐ **Yes** ☐ **No**

If you currently wear contacts...

Type of Contacts

☐ *1 Day* ☐ *2 Weeks* ☐ *1 Month* ☐ *1 Year* ____ *Brand Name*

Powers *Right Eye:* ____ *Left Eye:* ____

How often do you dispose your contact lenses: ____

Do you sleep with your contacts on: ☐ *Yes* ☐ *No* *How often:* ____

Financial Statement

I hereby authorize Dr. Quang Pham to release or exchange any information necessary to process my insurance claim. I will receive services with the understanding that in the event my coverage is not effective, I will be billed by Dr. Quang Pham and will be held financially responsible for services rendered. Furthermore, I understand what my benefits are and that there may be additional charges over and above those covered by my benefits.

Payment Type: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Acknowledgement of Receiving Notice of Privacy Practices

I acknowledge that I received a copy of Quang Pham, O.D.'s Notice of Privacy Practices. In addition, I agree to the Financial Statement and certify that all the information provided is correct and current to the best of my knowledge.

Signature ____ *Date* ____