Welcome to Fountain Valley Optometry!

DATE: _______________

Patient's Name: ____
First Middle Last

(***If Patient is under 18***) Name of Parent or **Guardian**: ____

Sex: ☐ Male ☐ Female Date of Birth: __________________ S.S. #: _________-________-___________

Address: _______________________________________ ______ ______________________________ _____________
Number & Street Apt. # City & State Zip Code

Home Phone #: _____________________ Cell Phone #: _____________________ Work Phone #: ___________________

Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced Email: _____________________________

Employer: _______________________________________ Occupation/Job Title: _________________________________

Referred by: ☐Friend or Relative (Name) ________________________________ ☐ Walk-In

☐Employer/Insurance ☐Radio☐ Yellow Pages ☐ Yelp ☐ Other __________________

Purpose of Today's Visit:
☐Glasses ☐Contact Lenses ☐ Routine ☐ Red Eye ☐ Laser Eye Surgery ☐Other __________________

Insurance Information

Name of Vision Insurance: ______________________________________ Policy/ ID #: ___________________________

Name of Primary Card Holder: ______________________________ S.S. #: ______-_____-_________ DOB:____________

Brief Case History

Last Eye Exam: _____ years ago

Have you ever worn glasses or contact lenses? ____Yes ____ No
If yes, when was the last pair prescribed? ________________________________

Do you use computers? ____Yes ____No If yes, how many hours a day: _____________________________________

Hobbies/ Sports (Information used to help determine your prescription): ____

Do you suffer from? (Check all that applies)
___ Blurred vision (Circle one: Far/ Near/ Both) ___ Headaches ___ Itchy Eyes ___ Light sensitivity
___ Reduced night vision ___ Pain in eyes ___ Flashes/floaters ___ Eye strain ___ Burning sensations
___ Discomfort from glasses ___ Red eyes ___ Dry eyes ___ Watery eyes

Have you ever had any of the following conditions? (Check all that applies)
___ Eye injury ___ Eye surgery ___ Cataract ___ Glaucoma ___ Diabetes
___ High blood pressure ___ Heart conditions ___ Cancer ___ Allergies ___ Thyroid problems
___ Respiratory problems ___ Nervous conditions ___ Other eye diseases: ___________________________________

Current Medications: ____

Has anyone in ***your family*** suffered from any of the following? (Check all that applies)

___ Glaucoma ___ Blindness ___ Eye Diseases: ____

Do you smoke? ☐Yes ☐No If yes, how many packs a day? ____

Consent of Professional Services

I hereby authorize Fountain Valley Optometry/ Dr. Tina Dao to render optometry services and eye care to me and/or my dependent and accept the responsibility for payment of services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all of my insurance submissions from Fountain Valley Optometry.

____ Date: ____________________________________
Patient's Signature
(*Guardian's signature if patient is under 18*)