Dr. Stephen Chinn, O.D.

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____
Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Email _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ SSN _____
Sex M F
What is the purpose of this visit? Glasses/ Contacts/ other?_____
_____
Are you experiencing any problems with your current contact lenses or glasses?
_____
_____

Have you ever experienced, been diagnosed or treated for any of the following?

- ☐ Blurry Vision
- ☐ Burning
- ☐ Cataracts
- ☐ Corneal Abrasions
- ☐ Crossed eye/Eye turn
- ☐ Double Vision
- ☐ Eye Infections
- ☐ Eye Injury
- ☐ Flash of light
- ☐ Floaters/Spots
- ☐ Glaucoma
- ☐ Gritty eyes
- ☐ Headaches
- ☐ Iritis/Uveitis
- ☐ Itchiness
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Occasional dryness
- ☐ Retinal Detachment
- ☐ Sunlight Sensitivity
- ☐ Tearing
- ☐ Trouble at night
- ☐ Uncomfortable glasses
- ☐ Eye Fatigue/Strain
- ☐ Squinting
- ☐ Other eye disorders_____

Have you had any injuries or surgeries in your eyes? ☐ Yes ☐ No
If yes, What / Which eye/ When? _____
_____
_____
_____
_____
_____
_____
_____

Insurance Information

Please note that insurance does NOT cover the Contact Lens Evaluation and related follow up visits.
Vision Insurance_____
Sponsor Name_____
Sponsor SSN_____
Sponsor Address if different from patient address:
Street _____
City _____ State _____
Zip Code _____

Advance Beneficiary Notice: Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If your insurance company has not reimbursed our office in full within 60 days, you will be billed for your services. In the event that you do not make a reasonable effort to make payments, your account will be sent to a collection agency, and you will be charged a $90 collection fee.
Patient Name:_____
Signature_____
(Patient/Guardian)
Date:_____

Acknowledgement of Receipt of Notice of Privacy Policy: Please be advised that a copy of our HIPAA policy is posted in our office and is available by photocopy to all our patients. Please ask our staff if you would like to receive a copy of our Privacy Policy today. By signing below, I acknowledge that I have been made available a copy of Dr. Chinn's Notice of Privacy Policy.
Patient Name:_____
Signature:_____
(Patient/Guardian)
Date:_____

OFFICE POLICY:
You have 90 days following your Comprehensive Eye Exam to return for any glasses related follow- up visits at no charge. After 90 days, you will be charged $45 for a glasses refraction if there are any problems with your glasses. A Comprehensive Eye Examination is required after 12 months from your initial visit. The fee for this exam without insurance is $85. **Please note that there is no refund on spectacle purchases after the prescription lenses has been made.** _____ (initials)
(Patient/Guardian)

OVER PLEASE ⇨

The information in this confidential case history form is critical to the evaluation of your vision and health.

Medical History

Name of Family Physician_____
City/ State _____

Date of Last Eye Exam_____
By Whom?_____ Dilated? □ Yes □ No

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____
_____

Allergies to medications? □ Yes □ No
If so, what medications?_____
_____

Do you use cigarettes/tobacco, alcohol, or other substances? □ Yes □ No

Women: Are you pregnant or nursing? □ Yes □ No

Have you ever been diagnosed or treated for the following health problems?

□ Allergies (non-medication):_____ □ Arthritis: Duration _____
□ Blood/Lymph: Duration_____ □ Bronchitis: Duration _____
□ Cancer: Type/Duration_____ □ High Cholesterol: Duration _____
□ Diabetes: Type/Duration_____ □ Digestive: Duration _____
□ Ears/Nose/Throat: Duration _____ □ Endocrine (thyroid): Duration _____
□ Eczema/Rashes: Duration _____ □ Fatigue
□ Recurrent Fevers: Duration_____ □ Genitourinary
□ High Blood Pressure: Duration _____ □ Integumentory (Skin)
□ Kidney: Duration _____ □ Muscle/Bone : Duration _____
□ Neurological: Duration _____ □ Psychological: Type _____
□ Respiratory: Duration _____ □ Sinus
□ Throat Infections: Duration _____ □ Thyroid: Duration _____
□ Unusual weight losses/gains □Developmental/learning delay:_____

Is there a family medical history of any of the following: Relationship to you /(on Mother/ Father side)

Retinal Problems	□_____	Blindness	□_____
Macular Degeneration	□_____	Cataracts	□_____
Lazy Eye	□_____	Corneal Problems	□_____
Heart Disease	□_____	Diabetes	□_____
Hypertension	□_____	Glaucoma	□_____