

# Suzanne D. Huang, O.D.

## Welcome Back To Our Office

Welcome to Suzanne D. Huang, O.D.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.  Male  Female

X \_\_\_\_\_ X \_\_\_\_\_  
First Name MI Last Name Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

\_\_\_\_\_  
Email Address Guardian Person Responsible for Account X, X

\_\_\_\_\_  
Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book  School  Advertisement  Patient  
 Insurance Listing  Drive by  Other  Doctor

\_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

\_\_\_\_\_  
Name and Address of Primary Insurance Company City State Zip

M  F  \_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth  
**Patient Relationship to Insured** **Patient Status**  Single  Married  Other  
 Self  Spouse  Child  Other  Full Time Student  Part Time Student  Employed

### SECONDARY INSURANCE INFORMATION

\_\_\_\_\_  
Name and Address of Secondary Insurance Company City State Zip

M  F  \_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth **Patient Relationship to Insured**  
 Self  Spouse  Child  Other

### Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
Signature Date

Name **xx**

**Suzanne D. Huang, O.D.**  
**PATIENT HISTORY AND INFORMATION**

**Race**

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Declined To Specify
<input type="checkbox"/> Hispanic Or Latino	

Other Race

Ethnicity  Hispanic Or Latino  Not Hispanic Or Latino  Declined To

Preferred Language  English  Chinese  Dutch; Flemish  French  German  Hindi

Height	<input type="text"/> ft	<input type="text"/> in	<input type="text"/> cm/m	<input checked="" type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight	<input type="text"/>	<input checked="" type="radio"/> lbs	<input type="radio"/> kg
--------	-------------------------	-------------------------	---------------------------	--	--------------------------	-------------------------	--------	----------------------	--------------------------------------	--------------------------

**PRIMARY CARE PHYSICIAN**

Primary Care Physician and Clinic Name

Address of Primary Care Physician      City      State      Zip      Phone

**REFERRING PHYSICIAN**

Referring Physician and Clinic Name

Address of Referring Physician      City      State      Zip      Phone

**HEALTH HISTORY**

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

When was your last health exam ? \_\_\_\_\_

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

**EYE HISTORY**

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No		

**GENERAL HEALTH CONDITION**

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No

Other Symptoms  Yes  No  
 Ears, Nose, Throat  Yes  No  
 Cardiovascular (high blood pressure etc.)  Yes  No

Kidney  Yes  No  
 Muscles, Bones, Joints  Yes  No  
 Skin  Yes  No  
 Neurological (Multiple Sclerosis)  Yes  No

Blood/Lymph  Yes  No  
 Allergic  Yes  No  
 Pregnant  Yes  No  
 Nursing  Yes  No

Name **xx**

**Suzanne D. Huang, O.D.**

**MEDICAL HISTORY QUESTIONNAIRE**

**FAMILY HISTORY**

Amblyopia (Lazy Eye)  Yes  No  
 Blindness  Yes  No  
 Cataract(s)  Yes  No  
 Color Blindness  Yes  No  
 Glaucoma  Yes  No  
 Macular Degeneration  Yes  No

Retinal Detachment  Yes  No  
 Strabismus (Eye Turn)  Yes  No  
 Arthritis  Yes  No  
 Cancer  Yes  No  
 Diabetes  Yes  No  
 Heart Disease  Yes  No

High Blood Pressure  Yes  No  
 Kidney Disease  Yes  No  
 Lupus  Yes  No  
 Stroke  Yes  No  
 Thyroid Disease  Yes  No  
 Others  Yes  No

**SOCIAL HISTORY**

Current Occupation : \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

**SPECTACLE LENS HISTORY**

Do you use a computer?  Yes  No How many hours/day? \_\_\_\_\_ Distance from Computer? \_\_\_\_\_  
 Do you drive?  Yes  No Mileage to work each way? \_\_\_\_\_  
 Do you have glare problems?  Yes  No  
 Do you have visual difficulty when driving?  Yes  No  
 Do you have problems with night vision?  Yes  No  
 Do you currently wear glasses ?  Yes  No Since \_\_\_\_\_  
 Type of glasses  FullTime  PartTime  Distance  Close  
 Glasses Owned  SingleVision  Bifocals  Trifocals  Backup  Safety  Sports  Progressive  
 Have you had trouble in the past with glasses?  Yes  No \_\_\_\_\_  
 Do you wear sunglasses?  Yes  No Are your sun glasses your current prescription ?  Yes  No

**SPECIAL EYEWEAR NEEDS**

Computer (special prescriptions, special anti-glare tints or coatings)  Safety Glasses (gardening, woodworking, welding)  
 Occupational (mechanics, plumbers, pilots)  Sports/Hobbies (racquet sports, motorcycle)

**CONTACT LENS HISTORY**

If not a contact lens wearer, are you interested in trying contact lenses at this time ?  Yes  No  
 Have you ever tried to wear contact lenses?  Yes  No Reason for stopping? \_\_\_\_\_  
 Do you currently wear contact lenses?  Yes  No Since \_\_\_\_\_  
 Type and brand of contact lenses \_\_\_\_\_ Today's wearing time ? \_\_\_\_\_  
 How many hours/day ? \_\_\_\_\_ How many days/week ? \_\_\_\_\_

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

Right Left Right Left Right Left  
 Lens Comfort \_\_\_\_\_ Distance Vision \_\_\_\_\_ Near Vision \_\_\_\_\_  
 What Solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

Name **xx**

**Suzanne D. Huang, O.D.**

**SOCIAL HISTORY**

Do you use nutritional supplements (vitamins etc.)?  Yes  No  
 Do you engage in regular exercise?

Do you drink alcohol ? If yes, how much/often :

Yes  No

No  Occasional  1 Per Day  2-3/day  4+/day

Do you smoke ? If yes, how much/often :

No  Occasional  1/2 pack/day  1 pack/day  1+ pack

Smoking Status

Method of Tobacco Intake :

Smoking  Chewing

Do you use Illegal Drugs :

Yes  No

Hobbies/ Interests :

---