New Patient Information

Dr. Chester Quan, OD
Dr. Christina Chang, OD
Dr. Meng Deng, OD

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Sex: ☐ M ☐ F

Last Name: _____ First Name: _____ M. Initial :_____
Birth Date :_____ Race/Ethnicity(Optional): _____ Primary Language:_____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Cell Phone: _____ Work # :_____
Email Address: _____

Vision Insurance : _____ Primary Member's Name: _____
Primary's last 4 of SSN, Date of birth or SSN: _____

Patient History

Primary reason for today's visit: (check all that applies)
☐ Annual Eye Exam ☐ Contact Lens Exam ☐ Vision or Eye Health Problem ☐ Other
Last Complete Eye Exam:_____ Have you ever had your eyes dilated? _____ When?_____

Is there a **family history** of : (Please check all that applies)
☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Glaucoma ☐ Cataract ☐ Macular Degeneration
Relationship_____

Do **you** have: ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Glaucoma ☐ Cataract
☐ Macular Degeneration
Are you being treated for any other medical conditions? _____
Are you currently taking any medications? _____
Are you allergic to any medications? _____
Do you consider yourself a : ☐ Non-Smoker ☐ Current Smoker ☐ Former Smoker

Have you ever had any eye infection, disease, injury or surgery? _____
Do you have headaches which you think are related to your eyes? _____
Do you experience : ☐ Dry Eyes ☐ Light Sensitivity ☐ Poor night vision ☐ Glare issues

What sports and/or hobbies do you enjoy? _____

Are you currently wearing contact lenses? If so, which brand? _____
Are you interested in wearing contact lenses? ☐ Yes ☐ No
Do you sleep with your contacts? ☐ Yes ☐ No
Which lens care system do you use? ☐ Revitalens ☐ Optifree ☐ Clear Care ☐ Boston ☐ Other _____

Have you had Lasik? ☐ Yes ☐ No Are you interested in Lasik? ☐ Yes ☐ No

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I have read and understand the privacy policies of Visionarium Optometry's Practice.

Print Patient's Name: _____ Date:_____

Patient's Signature (Parent or Guardian if under 18yrs old)_____
Print Name of Parent/Guardian: _____ Relationship to Patient_____

***** Please send completed form to : visionarium@sbcglobal.net *****