Welcome To Our Office

Mission Optometric Center
Jimmy M. Quang, O.D.
Ryan K. Onishi, O.D.

Patient Information:

Thank you for choosing our practice for your eyecare needs. If you have any questions or concerns, please do not hesitate to ask.

Circle your title Mr. Mrs. Miss Ms. Dr. ***(Please Print)***

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Sex M / F Social Security # _____

Home phone # _____ Daytime phone # _____ Name you prefer to be called _____

Your/your parent's employer _____ Occupation _____

Business address _____ City _____ State ____ Zip _____

Spouse or parent's name _____ Workplace _____ Work phone # _____

If student, school/college name _____ City _____ State ____ Grade _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone # _____

EMAIL: _____ (For newsletters and appointment reminders)

Responsible Party:

Name of person responsible for account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Name of employer _____ Work phone # _____

Insurance Information:

Name of Insured _____ Relation to patient _____ Birthdate _____

Social Security # _____ Name of employer _____ Work phone # _____

Address _____ City _____ State ____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. address _____ City _____ State ____ Zip _____

YOU ARE RESPONSIBLE FOR THE COMPLETE BILL AND REMAINING BALANCE AFTER INSURANCE PAYMENT. IF APPLICABLE, WE WILL BILL YOUR INSURANCE COMPANY FOR SERVICES RENDERED. YOUR INSURANCE MAY REIMBURSE YOU.

Regarding the payment of your account: When contact lenses or glasses are ordered, full payment is requested following the exam.

Patient signature _____

Please continue on other side…

PATIENT HEALTH HISTORY

Personal Eye History:

Date of last eye examination _____ Name of eye doctor _____

Do you wear: Glasses Y N Contact lenses Y N If you wear contact lenses, please list type_____

Please list the name and address of the doctor who fit your contact lenses: _____

_____

Have you ever had any eye: Injury Y N date: _____ Surgery Y N date: _____ Loss of vision Y N

Have you ever been told that you have: Glaucoma Y N Macular degeneration Y N Cataracts Y N

If yes, please explain in detail: _____

Please list any other eye conditions: _____

Personal Medical History:

How is your general health? _____

Date of last physical examination: _____ Name of primary care doctor: _____

Do you have problems with any of the following?

Cardiovascular	Y N	Endocrine (glands)	Y N	Respiratory	Y N
High blood pressure	Y N	Thyroid	Y N	Ear/Nose/Throat	Y N
Cholesterol	Y N	Diabetes	Y N	Neurological	Y N
Musculoskeletal	Y N	Blood/Lymph	Y N	Immunologic	Y N
Skin	Y N	Constitutional	Y N	Genitourinary	Y N

If yes to any, please specify and/or list any other health problems: _____

_____

Are you presently taking any medications? Y N Birth control pills Y N Hormones Y N

Please list all medications: _____

_____

Allergies (including medication)? Y N If yes, please list: _____

Headaches Y N If yes, location? Front Side Top Back Neck

Use cigarettes/tobacco Y N Alcohol Y N Other substance Y N

Family Health History: *(Immediate only)*

High blood pressure Y N Relation _____		Diabetes Y N Relation _____	
Retinal detachment Y N Relation _____		Glaucoma Y N Relation _____	
Macular degeneration Y N Relation _____		Cataracts Y N Relation _____	

Any other family health/eye conditions Y N Please list: _____

Hobbies/Activities (Sports):

_____