BARRANCA OPTOMETRY
4482 Barranca Parkway, Suite 190
Irvine, CA 92604

Dr. Raymond Huang, O.D.
Dr. Crystal Muraoka,O.D.

Welcome to our office!

Date_____

Name: _____ Spouse: _____
Last First MI

Address: _____
City State Zip

Home #: _____ Work/Cell #: _____ Email: _____

Birthday ____/____/_____ Age _____ Sex _____ Occupation _____

Vision Insurance ID/SSN _____-____-_____ Employer _____

If the patient is a dependent, name of parent/guardian responsible for the account.

Name: _____Date of Birth_____Relationship to patient: _____

Date of last eye exam: _____ By whom? _____

Are you having problems seeing:
In the distance? □Y □N with glasses? □
Up close/reading □Y □N contacts? □
At computers? □Y □N or both? □

If you wear contacts, what brand/type do you use? RGP □ Soft □ Brand: _____

Have you or your family members ever been diagnosed with any of the following conditions?

	Yourself	Family	If a family member, what is the relationship?
High blood pressure	□Y □N	□Y □N	
Diabetes	□Y □N	□Y □N	
Thyroid disorder	□Y □N	□Y □N	
Heart disease	□Y □N	□Y □N	
High cholesterol	□Y □N	□Y □N	
Cancer (type_____)	□Y □N	□Y □N	
Glaucoma	□Y □N	□Y □N	
Macular degeneration (ARMD)	□Y □N	□Y □N	
Lazy eye (Amblyopia)	□Y □N	□Y □N	
Eye turn (Strabismus)	□Y □N	□Y □N	

Date of last physical exam: _____ By whom?_____
Do you currently take any medications? □Y □N If yes, please list _____
Are you allergic to any medication? □Y □N If yes, which ones? _____
Any other known allergies? □Y □N If yes, to what? _____
Have you had eye surgery? □Y □N If yes, what kind and when? _____

I authorize the release of medical information necessary to provide the most beneficial/complete visual examination. I understand that I am financially responsible for all charges whether or not paid for by insurance. Payment is due at the time services are rendered.

_____
Signature of patient or responsible party

CONTACT LENS PATIENT: Your success with contact lenses depends upon follow-up care. We would like to see you after one week of wearing your new diagnostic lenses. It is your responsibility to schedule and keep this appointment. Furthermore, contact lenses are medical devices. It can cause serious eye problems without proper care and routine follow-up. Therefore, **OUR OFFICE CANNOT RELEASE YOUR CONTACT LENS PRESCRIPTION WITHOUT FINALIZING YOUR CONTACT LENS EXAM WHICH INCLUDES THE FOLLOW- UP VISIT AT THE DOCTOR'S DISCRETION.**

Please sign below to indicate your understanding of our office policy.

_____
Signature of patient or responsible party