ANGELES
Vision Clinic

Dr. Eric Van Orman
OPTOMETRIC PHYSICIAN
Board Certified ABO
360-452-2100

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help.

Name	DOB	Today's Date
Mailing Address	City	Zip Code
Home Phone	Work Phone	Marital Status
Insurance	Occupation	
Subscriber	Employer	
ID#	Physician	
Referred by	S.S. Number	

1) Do you have any of the following conditions?

☐ Diabetes	☐ Seizures	☐ High Blood Pressure
☐ Sarcoidosis	☐ Digestive Problems	☐ Stroke
☐ Leukemia	☐ Heart Conditions	☐ Thyroid Problem
☐ Bleeding disorder	☐ HIV/AIDS	☐ Shortness of breath
☐ Asthma	☐ Hepatitis	☐ Shingles
☐ Temporal Arteritis	☐ MS	☐ Arthritis
☐ Tuberculosis	☐ Syphilis	☐ Crohn's Disease
☐ Lupus	☐ Pregnant	☐ Other_____

2) Do you have any family history of the following?

☐ Diabetes	☐ Blindness	☐ Turned or lazy eye
☐ Cataracts	☐ Glaucoma	☐ Macular Degeneration
☐ Retinal detachment	☐ Severe headaches	☐ Heart condition

3) Have you ever had any of the following eye symptoms/conditions?

☐ Cataracts	☐ Sensitivity to light	☐ Dry eye
☐ Macular Degeneration	☐ Floaters of spots	☐ Burning or itching
☐ Glaucoma	☐ Watery eye	☐ Corneal ulcers
☐ Turned or lazy eye	☐ Color deficiency	☐ Blindness
☐ Iritis/Uveitis	☐ Eye pain	☐ Numbness
☐ Retinal detachment	☐ Eye Infection	☐ Herpes Simplex

4) Do you have any of the following vision symptoms?

☐ Double Vision	☐ Poor near vision	☐ Tunnel vision
☐ Eye Strain	☐ Poor distance vision	

5) History of past eye surgery: Yes NO

- ☐ Cataracts
- ☐ Refractive Surgery
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Ocular tumors
- ☐ Ocular Trauma
- ☐ Lid Surgery
- ☐ Tear Duct
- ☐ Cosmetic

6) Do you smoke? Yes No If "No", Have you smoked in the past?

7) Please list all prescription medications and supplements you are currently taking:

_____

_____

_____

_____

_____

7) Please list any drug allergies:

_____

8) Do you currently wear eye glasses? Yes No

- ☐ All the time
- ☐ Reading Only
- ☐ Part time
- ☐ Computer Work
- ☐ Distance Only
- ☐ Other

9) Have you ever worn contact lenses? Yes No

- ☐ Soft
- ☐ Daily Wear
- ☐ Astigmatic
- ☐ Gas Perm
- ☐ Extended Wear
- ☐ Tinted
- ☐ Multi Focal
- ☐ Mono Vision

11) Are you interested/would you like to receive information on refractive surgery (LASIK/PRK)? YES NO

12) Has anyone in your family been into Angeles Vision Center before? YES NO

For Medicare part B/ Private Insurance/ MVA Work-Related Injury, I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Angeles Vision Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Angeles Vision Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Signature:_____Date:_____