WELCOME TO DR. DANIEL WHANG'S OFFICE
PATIENT INFORMATION
(Please print)

Patient Name_____ Birthdate_____ Age___ Sex ☐M ☐F

Parent/Guardian or Responsible Party_____ Relationship_____

Home phone #_____ Work #_____ Patient S. S. # _____

Address _____ City _____ State____ Zip_____

Occupation_____ Employer_____

VISION INSURANCE ☐N ☐Y Name_____ Policy #_____

Name of Insured _____ S. S. #_____ Date of Birth of Ins._____

MEDICAL INSURANCE ☐Y ☐N PRIMARY Ins. Name_____ Policy # _____

Name of Insured _____ S. S. #_____

SECONDARY Ins. Name _____ Policy # _____

Name of Insured_____ S .S # _____

Previous Eye Doctor _____ Date of Last Exam _____

Whom May We Thank For Referring You_____

Reasons For Exam:

☐ Routine Checkup ☐ New Frames/New Lenses ☐ Learning Disability ☐ Interest in LASIK
☐ Contact Lens Evaluation ☐ Referred from School or Work ☐ Blurred Vision ☐ Other_____
Please list any special Vision needs you may have: (i.e. Computers, Cards, Shooting, Sports, etc.)_____
_____

Have You Previously Worn Glasses? ☐ Y ☐ N If Yes, for ☐ Distance ☐ Reading ☐ Bifocals ☐ Prism

Have You Previously Worn Contacts? ☐Y ☐N If Yes, ☐ Soft ☐ Hard ☐ Gas Permeable

Individual & Family Health History

Self	Family	Self	Family	Self	Family	Self	Family
☐	☐ Eye Disease or Surgery	☐	☐ Glaucoma	☐	☐ High Blood Pressure	☐	☐ Allergies
☐	☐ Amblyopia (lazy eye)	☐	☐ Cataracts	☐	☐ Diabetes	☐	☐ Sinus
☐	☐ Crossed Eyes	☐	☐ Blindness	☐	☐ Heart Disease	☐	☐ Asthma
☐	☐ Eye Injury	☐	☐ ARMD	☐	☐ Lung Disease		
☐	☐ Dry Eyes	☐	☐ Thyroid	☐	☐ High Cholesterol		

☐ Other_____
Do You Use Cigarettes or Tobacco? _____ Alcohol? _____ Other Substances? _____
List any MEDICATIONS you are taking (prescription and non-prescription)_____
_____
List any MEDICATIONS to which you are ALLERGIC_____
_____

The information above is correct to the best of my knowledge. Please note- it is not the responsibility of our office to determine your insurance benefits – please know your plan benefits at the time of your appointment. I understand that I am responsible for payment of all services or materials provided to me. If I have insurance, and assignment is accepted by my doctor, I am responsible for any payments denied or not paid by my insurance.
Signature_____ Date_____