

Advanced Optical / Kim Doan, M.D.

3333 West Coast Hwy #201, Newport Beach, CA 92663

Phone: 949.645.6300

Fax: 949.645.6020

Welcome to Advanced Optical and thank you for choosing us for your eye health and vision care needs. In order to prepare for your evaluation and for us to provide you with the best care for your individual needs, please review and complete the attached forms.

General Information

Last Name: _____ First Name: _____ M.I. _____

Sex: M or F Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Vision Insurance Carrier: _____ Policy#: _____

How did you find out about our office? Doctor Social Media Friend

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I have certain rights to privacy regarding disclosure of my health information. I understand that this information may be used to direct treatment, payment, or health care operations. Unless I decline, relevant information may be shared with family involved in my eye care. I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I may request, in writing, to restrict how my information is shared. By signing below, I acknowledge the above and that I have reviewed or been given the opportunity to review Advanced Optical's Notice of Privacy Practices (*available on our website at www.advancedopticaleyes.com*), which further details the uses and disclosures of my health information.

Signature _____ Date _____

Advanced Optical / Kim Doan, M.D.

3333 West Coast Hwy #201, Newport Beach, CA 92663

Phone: 949.645.6300

Fax: 949.645.6020

Financial Agreement

I understand that I am financially responsible for all charges and it is my responsibility to pay balances not paid by insurance. **I understand that most insurances do not pay for refractions (to obtain an eyeglass prescription). If I have a refraction, I am responsible for the refraction fee of \$75.** Payment is due at the time services are rendered.

We, at Advanced Optical, sincerely appreciate your business and we strive to offer you the very best in products and services. Making high quality eyewear takes time and expertise. These are custom items made specifically for you in order to meet your needs. Hence these items cannot be reused or returned to the manufacturer. Therefore, there are no returns or refunds on any prescription eyewear. Rest assured we will make every effort to correct any issue you may have and work with manufacturers directly on your behalf. It is of the utmost importance to us that you are seeing well and you love the way you look and feel with your new glasses and/or contacts.

Signature _____ Date _____

Print Name _____ DOB _____ Initials _____

Advanced Optical / Kim Doan, M.D.

3333 West Coast Hwy #201, Newport Beach, CA 92663

Phone: 949.645.6300

Fax: 949.645.6020

Medical History Questionnaire

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Excess tearing | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Distorted vision | <input type="checkbox"/> Sandy/gritty feeling |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Burning | <input type="checkbox"/> Drooping eyelids |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Glare/light sensitivity halos | <input type="checkbox"/> Other _____ (explain below) |

Please **explain** any boxes you have checked:

Do you **currently** have a problem with any of these systems? Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> General/Constitutional
(fever, heat stroke, weight loss or gain, unusually tired, etc.) | <input type="checkbox"/> Ears/Nose/Throat
(hard of hearing, stuffy nose, earache, cough, dry mouth, etc.) |
| <input type="checkbox"/> Cardiovascular
(high BP, racing pulse, etc.) | <input type="checkbox"/> Respiratory
(congestion, wheezing, shortness of breath, etc.) |
| <input type="checkbox"/> Gastrointestinal
(stomach upset, diarrhea, constipation, hernia, ulcers, etc.) | <input type="checkbox"/> Genital, Kidney, Bladder
(painful/frequent urination, impotence, yellow jaundice, etc.) |
| <input type="checkbox"/> Musculoskeletal
(joint pain, stiffness, swelling, cramps, arthritis, etc.) | <input type="checkbox"/> Skin
(pimples, warts, growths, rash, etc.) |
| <input type="checkbox"/> Neurological
(numbness, headache, seizures, paralysis, etc.) | <input type="checkbox"/> Psychiatric
(anxiety, depression, insomnia, etc.) |
| <input type="checkbox"/> Endocrine
(diabetes, hypothyroid, etc.) | <input type="checkbox"/> Blood/Lymph
(bleeding, cholesterolemia, anemia, etc.) |
| <input type="checkbox"/> Allergic/Immunologic
(sneezing, swelling, redness, itching, hives, lupus, etc.) | <input type="checkbox"/> Other _____
(explain below) |

Please **explain** any boxes you have checked:

Print Name _____ DOB _____ Initials _____

Advanced Optical / Kim Doan, M.D.

3333 West Coast Hwy #201, Newport Beach, CA 92663

Phone: 949.645.6300

Fax: 949.645.6020

Any allergic reactions to medications or other substances (latex, etc.)? Yes / No

If yes, please list: _____

Name of general physician: _____ Phone number: _____

Do you smoke? Yes / No How much? _____

Do you drink alcohol? Yes / No How much? _____

Do you take medications? Yes / No Please list names and how often:

Do you use other substances? Yes / No

Do you have family history of any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Other heritable disease |

Please **explain** any boxes you have checked:

Print Name _____ DOB _____ Initials _____

Advanced Optical / Kim Doan, M.D.

3333 West Coast Hwy #201, Newport Beach, CA 92663

Phone: 949.645.6300

Fax: 949.645.6020

Vision & Lifestyle Questionnaire

Please complete this questionnaire so we can better understand your daily vision needs.

What is your occupation? _____

How many hours a day do you spend per activity?

Reading _____ Computer _____ Smart Phone _____ Tablet _____ Digital Equipment _____

Do you drive? Yes / No If so, any visual difficulties? _____

Do your eyes feel tired or strained at the end of the work day? Yes / No

Do you experience sensitivity to light? Yes / No

Does glare bother you? Yes / No

Do you regularly participate in outdoor exercise? If yes, please describe: Yes / No

Do you participate in any contact sports? If yes, please describe: Yes / No

Do you wear sunglasses with UV protection? Yes / No

Does driving at night bother you? Yes / No

Eyewear Needs

Daily Wear

Driving

Non-prescription Sunglasses

Prescription Sunglasses

Sport

Safety

Reading

Fashion Frames

Colored Contact Lenses

Occupational Needs

Computer Glasses

Protective

Absorption

Safety

What is important to you?

Comfort

Thin Lens

Optimized Vision

Glare Reduction

Updating Your Look

Backup Pair

Current Lens Technology

Melanoma Prevention

Please describe any additional eyewear needs you would like to address:

Print Name _____ DOB _____ Initials _____