optic EYE CARE

New Patient Intake Form
新病人表格

Date _____

MRN _____

Patient Information 病人信息				
FIRST NAME (名字)	LAST NAME (姓氏)	BIRTHDATE (出生日期) MM / DD / YYYY	GENDER (性别) ☐ M ☐ F	
ADDRESS (地址)	APT #	CITY (城市)	STATE (州)	ZIP CODE (邮编)
PHONE (电话号码)	EMAIL (电子邮件)			

Medical Information 医疗信息			
FAMILY DOCTOR (家庭医生)	PHONE (电话号码) ( ) -	PHARMACY (首选药房)	PHONE (电话号码) ( ) -

1. What is the reason for your visit? (您来访的原因是什么?)

☐ Blurry vision (视力模糊) ☐ Floaters (飞蚊症) ☐ Itchiness (眼痒) ☐ Watery eye (眼眵)

☐ Dry eyes (干眼症) ☐ Flashes of light (闪光) ☐ Eye discomfort (眼睛痛) ☐ Redness (眼红)

Other 其他原因 *(please explain 请解释)* _____

2. Date of last eye exam? (上次眼科检查日期) _____/_____/_____ **from which doctor? (哪位医生?)** _____

3. Have you ever had your eyes dilated? (您以前做过瞳孔放大吗?) ☐ No (没有) ☐ Yes (有)

4. Have you had any eye surgeries? (您以前做过眼科手术吗?) ☐ No (没有) ☐ Cataract surgery (白内障手术)

☐ Glaucoma surgery (青光眼手术) ☐ Retinal surgery (视网膜手术) ☐ LASIK

Other 其他手术 *(please list 请解释)* _____

5. Are you currently taking any medications? (您在服用任何药物吗?) ☐ No (没有) ☐ Yes (有) *(please list 请列出)*

_____

6. Any drug allergies? (您有药物过敏吗?) ☐ No (没有) ☐ Yes, (有) ☐ Penicillin 青霉素 ☐ Sulfa 磺胺

Other 其他过敏症 *(please list 请解释)* _____

7. Do you or any family members have (您或您的家庭成员有):

	SELF 我	FAMILY 家庭	NONE 没有
Diabetes (糖尿病)	☐	☐	☐
If SELF, what is your last recorded A1c? 如果您有，您最近的 A1c 记录是多少? _____			
High blood pressure (高血压)	☐	☐	☐
Heart disease (心脏病)	☐	☐	☐
Glaucoma (青光眼)	☐	☐	☐
Macular degeneration (黄斑变性)	☐	☐	☐
Retinal disease (视网膜疾病)	☐	☐	☐
Eye cancer (眼癌)	☐	☐	☐

☐ **CONSENT FOR TREATMENT:** I authorize Optic Eye Care to administer diagnostic and medical procedures as may be for proper ocular health care. **同意接受治疗:** 本人在此授权 Optic Eye Care 进行适当的眼部保健诊断和医疗程序。

☐ **OFFICE POLICY ON PAYMENT:** I understand that I am responsible for payment of all charges, including any deductible, copay, or any other balance not paid by my insurance at the time of billing. I authorize insurance benefits to be paids directly to the provider, if I request it. **办公室付款政策:** 我了解我有责任支付所有费用，包括任何免赔额、共付额或开账单时我的保险未支付的任何其他余额。如果我提出要求，我授权将保险金直接支付给医疗服务提供者。

☐ **DILATING DROPS:** Dilating drops are used to enlarge the pupils of the eye to allow for a better view of the inside of your eye. If required, I authorize my provider and/or assistants to administer dilating eye drops. **散瞳药水:** 散瞳药水用于放大瞳孔，以便更好地观察眼睛内部。如有需要，我授权我的医疗服务提供者和/或助理使用散瞳眼药水。

Patient Signature 病人签名 _____ **Date 日期** _____