Dr. Yan Ling Liang Optometry Professional Corporation

New Patient Registration

In order to provide you the best care possible, please complete this form, All information is strictly confidential.

Patient Information

Last Name		Home Phone		Occupation			
First Name		Cell Phone		Sunglasses	Y / N	Computer?	Y / N
BirthDate	MM/DD/YY			Driver's License	Y / N	Lic. Class	
Email *							
Address		Postal Code		How did you find us?			
	* To receive text message, or emails for appt reminders for communication.			Do you have insurance?			
( )	I give Consent to receive eye health tips.						

Vision History

Main reason for vision today? contact lens/glasses/vision change/others:

Current Symptoms

( ) Burning	( ) Redness	( ) Dryness	( )Double Vision	
( )Itching	( ) Tearing	( ) Pain	( )Blurred Vision	

Do you wear glasses?	Y / N	**Type:**	Distance	Readers	Bifocal	Trifocal	Progressive
Do you wear contacts?	Y / N	**Type:**	Daily	Biweekly	Monthly	Yearly	RGP/Hard

Eye Conditions?

( ) Amblyopia (Lazy eyes)	( ) Cataract	( ) Retinal Detachement	( ) Blepharitis	( ) Eye Infection
( ) Strabismus (eye turn)	( ) Glaucoma	( ) Macular Degeneration	( ) LASIK	( ) Eye Injury
( ) Dry Eyes	( ) Keratoconus	( ) Diabetic Eye Disease	( )Uveitis/Iritis	( ) Eye surgery

Medical History

( ) Cancer	( ) Heart	( ) Asthma	( ) Multiple Sclerosis	**Allergies**
( ) Diabetes	( ) Stroke	( ) COPD	( ) Sarcoidosis	
( ) Hypertension	( ) Arthritis	( ) Thyroid	( ) Anemia	
( ) Cholesterol	( ) HIV/AIDs	( ) Lupus	( ) Hepatitis	

Doctor:		Doctor Phone:		Doctor Fax:	

Medications

Social History

( ) Smokes	Packs/day:	( ) Cell phone	# hours:	Hobbies
( ) Alcohol	Amount:	( ) Tablet use	#hours:	

Family History

( ) Blindness	( ) Crossed/Lazy Eye	( ) Macular Degeneration	( ) Cancer	( ) Heart
( ) Cataract	( ) Glaucoma	( ) Retinal Detachment	( ) Diabetes	( ) Stroke

Eye Exam $145, Contact Lens Fitting Fee: $75 Sph, $120 astigmatism, $200 multifocal, Dry Eye Test $120, Orthokeratology $2000+

Achnowledgement of Above Information

I certify that the information provided on this form is accurate and I wish to continue my care under said terms.

Signature

Date