RICHARD H. YOOK M.D. INC. **Email:**
8719 LINDLEY AVENUE NORTHRIDGE, CA 91325▪TEL NO. (818) 993-5410▪FAX (818) 993-8300

PATIENT INFORMATION - PLEASE PRINT

		DATE OF BIRTH	**AGE**
LAST NAME	**FIRST NAME**	**INITIAL**	
ADDRESS: STREET	**CITY**	**STATE**	**ZIP CODE**
SOCIAL SECURITY NO.	**CELL PH NO:** ( )	**HOME PHONE NO:** ( )	
SEX ☐MALE ☐FEMALE	**MARITAL STATUS ☐ SINGLE ☐MARRIED ☐WIDOWED ☐ DIVORCED**		

REFERRED BY: (DOCTOR, FRIEND, FAMILY/ OTHER)_____

DO YOU HAVE AN OPTOMETRIST?

WHO IS YOUR PRIMARY CARE PHYSICIAN?

PATIENT OCCUPATION:_____

RESPONSIBLE PARTY INFORMATION: (IF DIFFERENT THAN ABOVE)

			DATE OF BIRTH
NAME: LAST	**FIRST**		**INITIAL**
RELATIONSHIP TO PATIENT:		**PHONE:** ( )	
EMPLOYER:	**OCCUPATION:**		

INSURANCE INFORMATION- PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE:	**NAME OF MEMBER**	**DATE OF BIRTH**	**RELATION TO PATIENT**
SECONDARY INSURANCE:	**NAME OF MEMBER**	**DATE OF BIRTH**	**RELATION TO PATIENT**

I HAVE WORN GLASSES SINCE AGE_____ **☐FULL TIME** **☐READING ONLY**

DATE OF LAST EXAMINATION FOR GLASSES_____. **WERE THE GLASSES CHANGED? Y / N**

I HAVE WORN CONTACTS SINCE AGE_____. **☐ HARD** **☐SOFT**

HAVE YOU HAD ANY *INJURY* TO YOUR EYES IN THE PAST?

LIST ALL KNOWN EYE DISEASES THAT YOU HAVE *NOW* OR *HAVE HAD* IN THE PAST:

LIST ALL EYE OPERATIONS YOU HAVE HAD:

LIST ALL MEDICATIONS YOU *PRESENTLY* USE FOR YOUR *EYE*. (WITH AND WITHOUT PRESCRIPTION)

SOCIAL HISTORY:

HAVE YOU EVER HAD A BLOOD TRANSFUSION? **☐YES** **☐NO** **IF YES WHEN:**_____.

DO YOU DRINK ALCOHOL? **☐ YES** **☐ NO** **IF YES HOW MUCH**_____.

DO YOU SMOKE? **☐YES** **☐ NO** **IF YES HOW MANY YEARS?**_____.

PLEASE COMPLETE THE OTHER SIDE

MEDICAL HISTORY

MAJOR ILLNESS- PLEASE CHECK IF YOU *HAVE* OR *HAVE EVER HAD*

		☐STROKE ☐TIA ☐CVA
☐AIDS/ IMMUNE DISORDER	☐HIGH BLOOD PRESSURE	☐VENEREAL DISEASE
☐ARTHRITIS	☐KIDNEY DISEASE	☐PARALYSIS OF ARMS AND/OR LEGS
☐CANCER	☐THYROID DISEASE	***OTHERS LIST BELOW:***
☐DIABETES	☐TUBERCULOSIS	☐_____
☐HARDENING OF ARTERIES	☐SERIOUS HEAD INJURY	☐_____
☐HEART DISEASE	☐SEIZURES (EPILEPSY)	☐_____

SURGERY- LIST ALL OPERATIONS YOU HAVE HAD:_____

LIST ALL MEDICATIONS YOU ARE PRESENTLY USING (INCLUDING VITAMINS & ANY OTC MEDICINES:

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

FAMILY HISTORY

IS THERE ANYONE WITHIN YOUR BLOOD RELATION WHO HAS OR HAS HAD: (LIVING OR DECEASED)

☐BLINDNESS	☐HISTORY OF EYE SURGERY	☐HEART DISEASE
☐CATARACTS	☐LAZY EYE (AMBLYOPIA)	☐STROKE
☐CROSSED EYES OR CROOKED EYES	☐RETINAL DETACHMENT	☐CANCER
☐DIABETES	☐SEIZURES	☐THYROID
☐GLAUCOMA	☐TUBERCULOSIS	☐ARTHRITIS

IN CASE OF EMERGENCY PLEASE CONTACT:

LAST NAME **FIRST NAME** **INITIAL** **RELATION**

STREET ADDRESS **CITY** **STATE** **ZIP** **PHONE**

NEXT OF KIN: **(IF DIFFERENT FROM ABOVE)** **NEXT OF KIN PHONE:**

PLEASE READ:

I UNDERSTAND THAT DROPS MAY BE USED DURING MY EXAMINATION WHICH MAY AFFECT MY VISION FOR DRIVING A CAR AFTERWARDS. I AM WILLING TO WAIT UNTIL THE EFFECTS OF THE DROPS HAVE SUBSIDED BEFORE DRIVING MYSELF.

ASSIGNMENT AND RELEASE: I, the undersigned, assign directly to NORTHRIDGE OPHTHALMOLOGY ASSOCIATES all medical insurance benefits. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize NORTHRIDGE OPHTHALMOLOGY ASSOCIATES to release all information necessary to secure the payment of medical insurance benefits.

PLEASE REMEMBER THAT PAYMENT IS YOUR RESPONSIBILITY REGARDLESS OF INSURANCE INVOLVEMENT.

SIGNATURE: (PATIENT OR GUARDIAN) **DATE**