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, emails for appt reminders, pandemic & snowday changes. Do you have insurance?

Vision History

Main reason for vision today? Glasses/Contacts/Myopia/Concussion/Learning Attention:

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

( ) I give Consent to receive eye health tips.

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