ALICE CHIANG, M.D.

1002 Mendocino Avenue
Santa Rosa, Ca 95401

PATIENT INFORMATION

First Name_________________________ Last Name________________________ Middle_______ Date of Birth_____/_____/_____

Address____City________________________________Zip______________

Phone: Home_____________________ Work _____________________Cell_____________________ Sex: Male / Female

Marital Status: Single /Married /Divorced /Separated/Widowed/Domestic Partner SS#__________/________/__________

Occupation_________________________________Employer_______________________Employer Phone___________________

Emergency Contact_____________________________ Phone_____________________

Primary Care Doctor____

☐ I would like to be notified of special events by email. Email Address: ____

Insurance Information

Primary Insurance: __________________________________ ID#_______________________ Group#___________________

Guarantor Information (primary insured) First Name__________________________ Last Name_________________________

Date of Birth__________/________/____________ SS#________________/__________/________________ Sex: M / F

Secondary Insurance: ________________________________ ID#_______________________ Group#_____________________

Guarantor Information (primary insured) First Name__________________________ Last Name__________________________

Date of Birth__________/________/____________ SS#________________/__________/________________

Vision Insurance*:* *VSP / EyeMed / Davis Vision / Spectera / MES* **ID#** _____________________________

I understand that if my insurance does not cover services I received from Dr. Alice Chiang at Artemedica Optica that I am responsible for payment of all charges incurred to my account.

Privacy Notice: Alice Chiang, M.D. and Staff at Artemedica Optica are in accordance with HIPPA regulations.

_____________________________________ _________________

Patient Signature (if under 18, must be parent or Legal Guardian) ***Date***

ALICE CHIANG, M.D.
1002 Mendocino Avenue
Santa Rosa, Ca 95401

MEDICAL HISTORY

Condition:	Yourself:	Blood Relatives:	Condition:	Yourself:	Blood Relatives:
AIDS/HIV			High Blood Pressure		
Alzheimer's Disease			Kidney Disease		
Artificial Heart Valve			Lazy Eye		
Artificial Joints			Lupus		
Asthma			Macular Degeneration		
Bleeding			Migraines		
Blindness			Pacemaker		
Cancer			Parkinson's Disease		
Cataracts			Poor Color Vision		
Chemical Dependency			Psychiatric Conditions		
Cholesterol			Retinal Disease		
Dementia			Rheumatic Fever		
Diabetes			Seizures		
Drug Sensitivity			Shingles		
Emphysema			Sinusitis		
Epilepsy			Stroke		
Eye Surgery			Thyroid Conditions		
Glaucoma			TIA's		
Hay Fever			Tuberculosis		
Heart Conditions			Turned Eye		
Hepatitis					

Medications: (Please list all medications that you are currently taking; including eye drops, herbal supplements and over-the-counter medications.)

ALICE CHIANG, M.D.

1002 Mendocino Avenue
Santa Rosa, Ca 95401

Allergies: (Please list any allergies to any medications and / or any substance that cause an allergic reaction.)

Surgical History: (Please indicate if you have undergone any of the following surgical procedures)

Cosmetic:	**Yes or No**	***Other Surgeries:***	**Yes or No**	***Other Procedures:***	**Yes or No**
Blepharoplasty		Aortic Aneurysm		Bone Marrow Biopsy	
Eye/Facelift or Nasal		Arthroscopy		Hydrothermal Ablation	
Lateral Tarsal Strip		Coronary Artery Bypass		Lasik	
Organ Removal/ Resection		Cardiac Valve		LEEP	
Appendix		Carotid Endarterectomy		Liver Biopsy	
Colon		Coronary Artery Stent		Lumbar Puncture	
Gall Bladder		Coronary Angioplasty		PRK	
Larynx		Fracture Repair		Renal Biopsy	
Lung		Hernia Repair		Skin Biopsy	
Parathyroid		Hysterectomy		**Any other Surgical Procedures:**	
Sinus/Nasal		Ovaries Removed			
Small Bowel		Joint Replacement			
Spleen		Laminectomy			
Thyroid		Laparotomy			
Tonsils		Tubal Ligation			
Uvula					

Social History:

Are you currently pregnant?		Caffeine:		Amount of caffeine per day	
Number of children?		Smoking:		Year stopped smoking?	
Exercise?		Alcohol:		Year stopped?	
Are you dieting		Drug Use:		What drug types?	

ALICE CHIANG, M.D.

1002 Mendocino Avenue
Santa Rosa, Ca 95401

ARTEMEDICA OPTICA QUESTIONAIRE

(division of Alice Chiang, M.D.)

Please answer the following questions with a check in the appropriate box.

1. Where are you having problems with your vision?

- ☐ Distance
- ☐ Reading/ Close Up
- ☐ Computer/ In Between

2. Do you have any problems with Bright Lights or Glare?

- ☐ Yes
- ☐ No

If yes, explain:

3. Do you have any problems driving at night?

- ☐ Yes
- ☐ No

If yes, explain

4. Do you use a computer?

- ☐ Yes, all the time
- ☐ Yes, but not heavily
- ☐ No

5. Do you enjoy reading for extended periods of time?

- ☐ Yes, I read for 30 minutes or more daily
- ☐ Yes, I read a few times a week
- ☐ No, I rarely read

6. Do you currently wear sun protections for your eyes?

- ☐ Yes, I wear prescription sunglasses
- ☐ Yes, I wear non prescriptions sunglasses
- ☐ No, I currently do not wear sun protection

7. When do you wear your current glasses?

- ☐ I wear them all the time
- ☐ I only wear them for distance
- ☐ I only wear them for reading
- ☐ I only wear them at the computer
- ☐ I only wear contact lenses
- ☐ I currently do not wear any glasses

8. If you wear glasses, what do you like about your current eyewear?

- ☐ Style
- ☐ Color
- ☐ Shape
- ☐ Fit
- ☐ Durability
- ☐ Lenses

9. What do you dislike about your current glasses?

- ☐ Style
- ☐ Color
- ☐ Shape
- ☐ Fit
- ☐ Durability
- ☐ Lenses