PRECISION EYE CARE
DR. VICTORIA YU, O.D.
300 E. DIMOND BLVD. STE.14
ANCHORAGE, AK 99515
P 907-646-9990 F 907–646–9935

PATIENT REGISTRATION FORM

Name (Last, First, Mi): _____ Date of Birth: ___/_____/_____
Sex: ☐ M ☐ F Address: _____
City: _____State: _____ Zip: _____
Phone: (Home)_____ (Daytime)_____ Email _____
Employer: _____ Occupation: _____
Please indicate the best of communication (ex. cell, text message, phone, email)

Are any family members patients of ours? If so, please share below:

How did you hear about us?
☐ Family Member ☐ Friends/Co-workers ☐ Insurance ☐ Website ☐ Yellow Page ☐ Other

RESPONSIBLE PARTY

☐ Self ☐ Parents/Guardian ☐ Insurance
Primary Insurance
Name of Insured _____ Date of Birth of Insured _____/_____/_____
SSN/ID No. _____
Relationship to the Patient:
☐ Self ☐ Parents ☐ Spouse ☐ Other
Address/Phone No. (If different from above) _____
Employer _____ Plan Name _____ Plan No./ Group No. _____

Secondary Insurance
Name of Insured _____ Date of Birth of Insured _____/_____/_____
SSN/ID No. _____
Relationship to the Patient:
☐ Self ☐ Parents ☐ Spouse ☐ Other
Address/Phone No. (If different from above) _____
Employer _____ Plan Name _____ Plan No./ Group No. _____

I authorize the release of any medical or the information necessary to process my insurance claim. I authorize payment for these benefits to YIM Corporation (DBA, Precision Eye Care, Dr. Victoria Yu, O.D.). I understand that payment for these services is my responsibility, and agree to pay for any portion not covered by my insurance carrier.

I have been presented with the Notice of Privacy Practice by Precision Eye Care, and have been offered a copy of such policy to keep for my record.

I understand that the payment is required at the time of service rendered, unless other arrangement is made in advance.

Signature _____ Date _____

REASON FOR VISIT (please check all that apply):

☐ Annual Eye Exam ☐ Glasses ☐ Contact Lenses ☐ Surgical consultation ☐ Emergency

☐ Other (please explain) _____

If you were seen here before, please indicate any changes, or leave following blank.

Please check if you are experiencing any of the issues listed below:

☐ Blur at Far ☐ Blur at Near ☐ Double Vision ☐ Tearing or Burning Eyes ☐ Headaches
☐ Eye Fatigue ☐ Lazy Eye ☐ Flashes of Light ☐ Floater ☐ Burning Eyes ☐ Itchy Eyes
☐ Flashes/Halos ☐ Light Sensitivity ☐ Watery Eyes ☐ Twitching Eyelids ☐ Poor Vision

Date of Last Eye Examination _____/_____/_____ Previous Doctor _____
Previous Eye Injury, Surgery, Disease _____
_____
_____

Medical History:

Self	Family		Self	Family	
☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Thyroid Condition	☐	☐	Glaucoma
☐	☐	Macular Degeneration	☐	☐	Seasonal Allergies
☐	☐	Cataract	☐	☐	Retinal Detachment

Current Medical Conditions _____
_____
Medications _____
_____
_____
Allergies to any Medication _____
Do you currently wear Glasses? ☐ Yes ☐ No
☐ Single Vision ☐ Reading ☐ Trifocals ☐ Progressive ☐ Bifocals ☐ Polarized

Do you currently wear Contact Lenses? ☐ Yes ☐ No Type Worn: ☐ Soft ☐ Gas Perm

How often do you replace or dispose of your lenses?
☐ Daily ☐ 1 Month ☐ 2 Weeks ☐ More than 1 Month

What brand of solution do you use? _____
What is your typical wearing schedule? _____ hours/day _____ days/week
Are you interested in wearing Contact Lenses? ☐ Yes ☐ No Colors? _____
Are you interested in LASIK option at this time? ☐ Yes ☐ No
What sports or hobbies do you enjoy? _____
Do you work with computers? ☐ Yes ☐ No How often? _____ hours/day _____ days/week

Primary Care Physician _____ Date of Last Visit _____/_____/_____
Are you pregnant or nursing? ☐ Yes ☐ No Do you smoke, or have ever smoked? ☐ Yes ☐ No

Signature _____ Date _____