NEW PATIENT HISTORY FORM

Name: _____ Phone Number: _____
Social Security #: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Email Address: _____ Occupation: _____
Date of last exam: _____ Location: _____
Primary Care Physician_____ Phone_____

Circle any eye conditions that apply to you:

Cataracts/Macular Degeneration/Glaucoma/Diabetes/Diabetic Retinopathy/Dry Eye/Infection
Inflammation/Allergies/Flashes and/or Floaters/Iritis or Uveitis/Retina Defects or Degeneration
Other: _____

Circle any eye concerns that apply to you:

Redness/Burning/Itching/Tearing/Discharge/Other: _____

Circle any vision concerns that apply to you:

Blurred Vision/Eye Strain/Eye Pain/Severe Sensitivity to Lights/Headaches/Poor Night Vision/
Bothersome Night Glare/Double Vision/Total Loss of Vision/Additional Concerns: _____

Please tell us about your current corrective lenses (Circle any that apply)

What corrective lenses are you mainly using for distant vision? Glasses/Contacts/None
Describe the quality of your distant vision: Acceptable/May need improvement/Blurred

What corrective lenses are you mainly using for reading? Glasses/Contacts/None
Describe the quality of your reading: Acceptable/May need improvement/Blurred

What corrective lenses are you mainly using for computer? Glasses/Contacts/None
Describe the quality of your computer vision: Acceptable/May need improvement/Blurred

Do you have any of the following computer demands on your vision?

Computer use for extended periods- **YES/NO** Unusual work demands- **YES/NO**
Must simultaneously view paperwork and computer- **YES/NO** Use of Laptop- **YES/NO**
Use of Multiple desktop monitors- **YES/NO** Hours of computer use per day: _____

Do you have any of the following demands on your vision?

Poor reading skills or low reading performance- **YES/NO** Inconsistent sports vision performance- **YES/NO**
Slowness when shifting focus- **YES/NO** Difficulty with 3-D images, movies or TV- **YES/NO**
Any special outdoor demands- **YES/NO** _____ Extended night driving- **YES/NO**
Outdoors in direct UV exposure- **YES/NO** Reading outdoors- **YES/NO**

Do you currently, or have had, any problems in the following area?
(Please circle any that apply)

Constitutional: Cancer, Fatigue, Developmental disabilities

ENT: Hearing loss, Sinusitis, Laryngitis, Dry Mouth

Neurological: MS, Cerebral Palsy, Epilepsy, Tumor, Stroke, Migraines

Psych: Depression, Anxiety, Attention Deficit, Bipolar

Cardiovascular: Stroke, Hypertension, Heart Disease, Vascular disease, congestive heart failure

Respiratory: Asthma, Chronic Bronchitis, Emphysema, COPD

Gastrointestinal: Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease

Genitourinary: Kidney Disease, Prostate, STD, Pregnant, Nursing

Muscle/Skeletal: Arthritis, Osteoarthritis, Fibromyalgia, Muscular dystrophy, Gout
Ankylosing spondylitis, Osteoporosis

Integumentary: Eczema, Rosacea, Psoriasis, Herpes Simplex, Herpes Zoster

Endocrine: Diabetes **(TYPE 1 or 2**), Thyroid Dysfunction, Hormonal Dysfunction

Lymphatic: Anemia, Blood Loss, Ulcer, High Cholesterol

Allergy/Immune: Drug Allergies, Environmental Allergies, Rheumatoid, Lupus, Sjogren's syndrome

If yes to allergies, what are you allergic to? _____

Please list any medications (including dosage and frequency):

_____

_____

_____

_____

Social Activities: (Please Circle any that apply):

Alcohol use: Rarely/Socially/Weekly/Daily

Tobacco use: Cigarettes- how much/often? _____

Cigars, Pipe, Smokeless, Vape, Other: _____ Former Smoker/Never Smoker

Family Medical and Optical History **(Please circle any that apply)**

High Blood Pressure: Father, Mother, Brother, Sister, Son, Daughter

Diabetes: Father, Mother, Brother, Sister, Son, Daughter

Thyroidism: Father, Mother, Brother, Sister, Son, Daughter

Cancer: Father, Mother, Brother, Sister, Son, Daughter **Type of Cancer**_____

Macular Degeneration: Father, Mother, Brother, Sister, Son, Daughter

Glaucoma: Father, Mother, Brother, Sister, Son, Daughter

Please read the following and sign below

RESPONSIBILITY STATEMENT

It is your responsibility to know your insurance benefits and alert us to the fact that you have insurance. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay at the time of service for any deductibles, coinsurance, or any other balances not paid for by your insurance.

Insurance must be presented at time of service. If insurance is presented after the fact, it is the patient's responsibility to submit for reimbursement.

FINANCIAL RESPONSIBILITY

If your insurance does not cover today's services you will be financially responsible for all charges or any portion not covered. If you receive a bill after your visit, please contact your insurance with any questions regarding covered/non-covered amounts for services provided or refer to the Explanation of Benefits sent to you by your insurance.

There is a $10 charge for any forms needing to be filled out by the doctor, e.g. School Forms, Driver's License Forms, etc.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing.

CONTACT LENS FITTING

(If you wear contacts currently or want to be fitted for contacts)

Patients will require a contact lens fitting in addition to the evaluation if:

-You are a new contact lens wearer
-You are a new patient to our office and we didn't fit the contacts.
-Your current contact lens prescription has changed.
-The doctor needs to change the material/brand of your contact lenses.

Although all NEW patients to our office will incur the initial fitting fee, most established patients will only incur the evaluation if the doctor decides that a change is needed.

Your fitting fee will include insertion and removal instruction (if needed), initial solutions, and up to 3 pairs of trial contact lenses. A 3-month period (which includes 2 subsequent follow-up visits) is allotted for you to complete your contact lens fitting.

RETURN POLICY

All returns are subject to a restocking fee.

Some items, such as lenses, are a custom product and therefore not eligible for returns.

Returns must be made within 30 days of purchase

Patient Name: _____ **Date:** _____

Patient Signature (Guardian if under 18)**:**_____