NEW PATIENT INFORMATION

If you would like to become a new patient, please complete this form. Once you complete the form, you will be able to print the form and bring it with you when you visit our offices. We encourage all new patients to complete this form to reduce your wait time and to give you the best possible care. All of your information will be kept secure and strictly confidential and adheres to HIPAA privacy standards. We look forward to seeing you in the office.

Name:

Sex:

Street:

City:

State:

Zip:

Date of birth:

Age:

Social security Number

Email Address:

☐ Send me offers and appointment updates through email

Home phone

Cell phone

Office phone

Occupation

Employer

Marital Status

Name of Spouse

Employer

Please Complete If Under 18 Years of Age Or a Student

Father's Name

Employer

Mother's Name

Employer

Referring Physician

Primary Language Spoken

How did you hear about us?

☐ Neighbour / Friend ☐ Family Physician ☐ Print Ad ☐ Website ☐ Billboard

Other

CONTINUED ON NEXT PAGE

REASON for Visit. Briefly explain any current eye problems.

Local pharmacy?

Do You Wear Glasses?
◯ Yes ◯ No

Number Of Years:

Do You Wear Contacts
◯ Yes ◯ No

Number Of Years:

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Glaucoma ◯ Yes ◯ No
Cataracts ◯ Yes ◯ No
Blindness ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
◯ Yes ◯ No if YES, please explain:

2. Have you ever had any surgery?
◯ Yes ◯ No if YES, please explain:

3. Have you ever hospitalized?
◯ Yes ◯ No if YES, please provide date and explanation:

4. Do you take any medications?
◯ Yes ◯ No if YES, please list:

CONTINUED ON NEXT PAGE

5. Do you have any drug or food allergies?
◯Yes ◯No if YES, please list:

REVIEW OF SYSTEM
Do you currently have any of the following problems:
Chronic fever, unexpected weight loss/gain, fatigue
◯Yes ◯No if YES, please explain:

Ear/nose/throat problems (hearing loss, sinus, sore throat)
◯Yes ◯No if YES, please explain:

Heart problems (chest pain, irregular heart beat)
◯Yes ◯No if YES, provide date and explanation:

Respiratory (shortness of breath, wheezing, coughing)
◯Yes ◯No if YES, please explain:

Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)
◯Yes ◯No if YES, please explain:

Urinary problems (pain or discomfort, blood in urine)
◯Yes ◯No if YES, please explain:

Skin problems (rashes, excessive dryness)
◯Yes ◯No if YES, please explain:

CONTINUED ON NEXT PAGE

Musculoskeletal (muscle ache, joint pain, swollen joints)
◯Yes ◯No if YES,please explain:

Neurological (numbers, weakness, headaches, paralysis)
◯Yes ◯No if YES, please explain:

Psychiatric problems (depression, anxiety)
◯Yes ◯No if YES, please explain:

Do any medical or eye diseases run in your family
(diabetes, high blood pressure, Cancer, glaucoma, macular degeneration)
◯Yes ◯No if YES, please explain:

Please list any medications you are currently taking

Do you smoke?
◯Yes ◯No if YES, Ho Much

Drink alcohol?
◯Yes ◯No if YES, Ho Much

If employed, how many hours per week do you work?

Any changes in employment conditions?

BETTER ONE OR BETTER TWO?
The only way we can sort out whether reduced vision is a matter of a simple eyeglass adjustment or some other problem is to perform a REFRACTION. This measures the eyes' focusing ability. This is the familiar "better one or two" part of the exam where you look at the eye chart through the PHOROPTER.

CONTINUED ON NEXT PAGE

The rest of the eye exam, THE MEDICAL EYE EXAM, determines if there are other disorders or conditions causing difficulties. Both the MEDICAL EYE EXAM AND THE REFRACTION ARE ABSOLUTELY NECESSARY TO FULLY EVALUATE THE HEALTH OF YOUR EYES AND THE VISUAL SYSTEM. Why am I being charged a "REFRACTION FEE"?

Medicare and most other insurers will not pay for this vital part of the eye exam and will only reimburse for THE MEDICAL EYE EXAM component. The REFRACTION component has been made the patient's responsibility.

Acknowledgment. I have read the above information and I understand that the refraction is routinely a non-covered service. I accept full financial responsibility for the cost of the service. ($30.00). The co-pay and deductibles are separate and not included in the refraction fee of $30.00. Contact lens related exams or prescription changes are also non-covered services. As a courtesy, we will file for the refraction, and REIMBURSE YOU if your insurer does cover this cost.

Patient Signature * Date:

_____ _____

Print form and bring to your appointment