west kendall eye care

NEW PATIENT FORM & MEDICAL QUESTIONNAIRE

Date: _____/_____/_____ Patient Name: _____

Date of Birth: _____ Phone: ☐ Home: _____

Address: _____ ☐ Cell: _____

City, State, Zip Code _____ ☐ Work: _____

Email: _____

. * Please indicate preferred phone number by checking a box above

Occupation: _____ Employer _____

OR if Student, School: _____ Grade: _____

Social Security Number: _____ Emergency Contact: _____

Insurance: _____ Emergency Contact Phone: _____

Policy Number: _____ Emergency Contact Relationship: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Name of Primary Care Physician: _____ PCP Phone: _____

Name of Pharmacy: _____ Pharmacy Phone: _____

What is your reason for seeing Dr. Monzon today? _____

Do you wear glasses? ☐ NO ☐ YES If YES, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ NO ☐ YES If YES, how old is your present pair of lenses? _____

What are your current hobbies: _____

Do you drive? ☐ NO ☐ YES

If YES, do you have visual difficulty when driving? ☐ NO ☐ YES

If YES, please describe: _____

Have you experienced any of the following symptoms?

	NO	YES		NO	YES
Double Vision	☐	☐	Flashes & Floaters	☐	☐
Eye Dryness	☐	☐	Loss of Side Vision	☐	☐
Eye Itching	☐	☐	Light Sensitivity	☐	☐
Eye Watering	☐	☐	Pain on Eye Movement	☐	☐

REVIEW OF SYSTEMS / PERSONAL / FAMILY MEDICAL & OCULAR HISTORY

Are you allergic to any medications? YES or NO
If YES, explain: _____

Are you being currently being treated for any medical conditions? YES or NO
If YES, please indicate: _____
_____

Please list all medications you take (including oral contraceptives, aspirin, over-the-counter medications etc.):
_____
_____

Please list all major injuries, surgeries and/or hospitalizations you have had:
Dates: _____ Reason: _____
Dates: _____ Reason: _____

Are you pregnant or nursing? ☐ NO ☐ YES
Do you drink alcohol? ☐ NO ☐ YES If YES, what type / amount/ how often? _____
Do you use recreational drugs? ☐ NO ☐ YES If YES, what type / amount/ how often? _____
Do you use tobacco products? ☐ NO ☐ YES If YES, what type / amount/ how often? _____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Please note any family history (parents, grandparents, siblings, children, living or deceased) with the following conditions:

DISEASE / CONDITION:	SELF: **NO**	**YES**	FAMILY:	RELATIONSHIP TO PATIENT:
Arthritis	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment / Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Headaches / Migraines	☐	☐	☐	_____
Respiratory Issues	☐	☐	☐	_____
Allergies	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

If you answered YES to any of the above, or have a condition not listed, please explain & list medications:

Doctor Name: _____Doctor Signature: _____Date:_____

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CONTACT LENS EVALUATION

1. What type of contact lenses do you wear?

☐ Rigid ☐ Soft ☐ Extended Wear Brand: _____

2. Are they comfortable? ☐ NO ☐ YES

3. How frequently do you replace your contact lenses for a new pair?
   _____

4. How often do you sleep in your contact lenses?
   - ☐ Never
   - ☐ Occasionally sleep or nap
   - ☐ 1 to 3 nights per week
   - ☐ Everyday
   - ☐ Other _____

5. How frequently do you experience the below symptoms while wearing your contact lenses?

	Never	Sometimes	Always
Discomfort	☐	☐	☐
Dryness	☐	☐	☐
Deposits	☐	☐	☐
Tired Eyes	☐	☐	☐
Irritation	☐	☐	☐
Redness	☐	☐	☐

Would you prefer to wear contact lenses that require regular cleaning or lenses that do not need to be cleaned?

- ☐ I prefer to clean and store my contact lenses
- ☐ I would like the convenience of lenses that do not require regular cleaning

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*** A contact lens fitting and/or evaluation is NOT part of a routine eye exam and is not usually covered by insurance.**

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DATE: _____

1. **A FIFTY PERCENT (50%) DEPOSIT IS REQUIRED ON ALL FRAME AND LENS ORDERS.** Initial _____

2. **ALL FRAMES HAVE A ONE YEAR MANUFACTURER DEFECT WARRANTY AS OF THE DATE OF PURCHASE.** Initial _____

3. **IF THE ORDER IS NOT PICKED UP WITHIN 30 DAYS FROM DATE OF PURCHASE, THE PATIENT WILL LOSE THEIR 50% DEPOSIT.** Initial _____

4. **THERE WILL BE A $20 FEE FOR USING PATIENT OWNED FRAMES ON GLASSES ORDERS. WKEC/OPTICAL LAB IS NOT RESPONSIBLE FOR POF BROKEN.** Initial _____

I authorize Dr. Monzon to submit information necessary to my insurance carrier for payment.

Signature (Patient/Guardian): _____ Date: _____

CONSENT TO TREAT

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I _____ (PRINT NAME) certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ (SIGNATURE OF PATIENT OR GUARDIAN)

_____ (DATE)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (PRINT NAME) have received a copy of this office's Notice of Privacy Practices.

_____ (SIGNATURE OF PATIENT OR GUARDIAN)

_____ (DATE)

□ PATIENT REFUSED TO SIGN ABOVE – SIGNATURE OF EMPLOYEE _____