New Patient Information

Name: Mr. Mrs. Ms. Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_

Primary Number: Home Work Cell Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male Female Marital Status: Single Married Other

Vision Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you: Drink Smoke Use smokeless tobacco Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_

Payment is due when services are rendered unless prior arrangements have been made.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle all that apply to you or circle “NONE” if none apply.

Neurological Musculoskeletal Respiratory Genitourinary

NONE NONE NONE NONE

Multiple Sclerosis Arthritis Smoker Kidney Disease

Epilepsy Osteoarthritis Asthma Prostate Disease

Cerebral Palsy Fibromyalgia Bronchitis STD\_\_\_\_\_\_\_\_

Tumor Muscular Dystrophy Emphysema Benign Prostate

Stroke/CVA Ankylosing Spondylitis COPD Hypertrophy

Migraine Osteoporosis Sleep Apnea Pregnant

Autism Spectrum Disorder Gout Other: \_\_\_\_\_\_\_ Nursing

Other: \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_

Cardiovascular Gastrointestinal Integumentary ENT

NONE NONE NONE NONE

Hypertension Crohn’s Eczema Hearing Loss

Stoke/CVA Colitis Rosacea Sinusitis

Heart Disease Ulcer Psoriasis Dry Mouth

Vascular Disease Acid Reflux Cold Sores Laryngitis

CHF Celiac Disease Shingles Other: \_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_

Psychiatric Endocrine Hematologic/Lymphatic Allergy/Immune

NONE NONE NONE NONE

Depression Diabetes Type 1 Anemia Environmental Allergies

Attention Deficit Diabetes Type 2 Large-volume blood loss Rheumatoid Arthritis

Anxiety Disorder Thyroid Disfunction Ulcer Lupus

Bipolar Disorder Hormonal Dysfunction High Cholesterol Sjogren’s Syndrome

Other: \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_

Constitutional Developmental Disabilities Cancer Fatigue Syndrome Other: \_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Condition | Father | Mother | Brother | Sister | Son | Daughter |
| Cancer | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Diabetes 1 | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Diabetes 2 | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Hypertension | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Hyperthyroid | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Cataracts | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Glaucoma | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |
| Macular Degeneration | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N | N/R U Y N |

N/R- Not Relevant U- Unknown Y- Yes N- No

Have you ever had any of the follow eye problems? If so, please describe in detail.

Glaucoma Suspect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Degeneration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Hole: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataract: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Detachment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age-Related Macular Degeneration: Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­­ Keratoconus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patching: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry Eye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inflammatory Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nystagmus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Strabismus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amblyopia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Encounter Questions

Please circle what you are here for today:

Routine Eye Exam Post Op Cataract Surgery Eye Problem

Contact Lens Evaluation Glaucoma/IOP Check Post Op Lasik Exam

Is today’s visit related to: Employment Auto Accident Other Accident

Circle any of the following conditions that you have been diagnosed with:

Cataracts Eye infection, inflammation, or allergy

Age-Related Macular Degeneration Floaters and/or flashes of light

Glaucoma Iritis or Uveitis

Diabetes Retina defects or degeneration

Diabetic Retinopathy Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dry Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following eye concerns you are having:

Redness Blurred Vision Severe sensitivity to light

Burning Eye Strain Bothersome night glare

Itching Eye Pain Double vision

Tearing Headache Total loss of vision

Discharge Poor night vision Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What corrective lenses are you mainly using for far/distant vision activities? None Glasses Contact Lenses

What is the quality of your far/distant vision activities? Acceptable May need improvement Blurred

What corrective lenses are you mainly using for near/reading vision activities? None Glasses Contact Lenses

What is the quality of your near/reading vision activities? Acceptable May need improvement Blurred

What corrective lenses are you mainly using for computer vision activities? None Glasses Contact Lenses

What is the quality of your computer vision activities? Acceptable May need improvement Blurred

Please tell us any about additional concerns with your current corrective lenses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Lens History:

What brand of contacts are you currently wearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old are the lenses you are currently wearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep in your contacts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average daily wearing time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s wearing time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average replacement period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Continuous wear period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Solutions used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drops used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received 2020 Eyecare’s Notice of Privacy Practices.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any physician, staff, employee or representative of 2020 Eyecare has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment, and payment.

Name: Relationship: Phone Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2020 Eyecare calls and sends recall notices for appointments via text, call, and occasionally we may send a post card via mail if we are unable to reach you.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to 2020 Eyecare or complete a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to re-disclosure by the individuals.

Paitent or Guardian’s Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_