NEW PATIENT FORM

GENERAL INFORMATION

Patient First, MI, Last Name, Preferred Name _____ Birth Sex: Male | Female

Street Address _____

City, State, Zip _____

Cell Phone _____ Secondary Phone _____

Email _____

Preferred Contact Method: Cell Phone | Home Phone | Text | Email | Other _____

Date of Birth _____ Patient's Social Security # _____

Occupation/Employer _____ Full-time | Part-time

Marital Status: Married | Single | Divorced | Legally Separated | Widowed _____

Language, Race, Ethnicity _____

Emergency Contact Person and Phone _____

How did you hear about us? _____

INSURANCE INFORMATION

Vision Insurance _____

Vision Insurance Member Name _____

Vision Insurance Member ID # _____

Vision Insurance Member Date of Birth _____

Medical Insurance _____

Medical Insurance Member Name _____

Medical Insurance ID # _____

Medical Insurance Policy # / Group ID # _____

Primary Member Date of Birth _____ Primary Social Security # _____

Patient's Relationship to Primary Member: spouse | child | other (please explain) _____

I, the undersigned authorize payment from my insurance company to be made to Eye Smile Optometry for covered services. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurance status, I am ultimately responsible for the balance on my account. Should timely payments of this account not be made, I authorize Eye Smile Optometry to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such an action shall become an additional liability for which I am responsible.

I certify that the information I have recorded with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.

I have reviewed a copy of Eye Smile Optometry's notice of Privacy Policies.

_____ _____ _____

Print Name Signature Date

NEW PATIENT FORM

EYE HISTORY

Reason for Today's Visit:

- ❒ Comprehensive Eye Exam
- ❒ Contact Lens Exam (including Comprehensive)
- ❒ Medical Office Visit

Primary Complaint: _____

_____

_____

Date of Last Eye Exam _____

Currently Wear Glasses? _____ Yes No

Currently Wear Contacts? _____ Yes No

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts _____ Self No Family

Glaucoma _____ Self No Family

LASIK or PRK _____ Self No Family

Lazy Eye / Eye Turn _____ Self No Family

Macular Degeneration _____ Self No Family

Retinal Detachment _____ Self No Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ❒ Blurry Vision _____ Distance | Near
- ❒ Eye Strain _____
- ❒ Redness _____
- ❒ Dryness _____
- ❒ Sandy or Gritty Feeling _____
- ❒ Burning _____
- ❒ Itching _____
- ❒ Discharge _____
- ❒ Excess Tearing or Watering _____
- ❒ Eye Pain or Soreness _____
- ❒ Double Vision _____
- ❒ Floaters or Spots _____
- ❒ Halos _____
- ❒ Headaches _____
- ❒ Light Flashes _____
- ❒ Light Sensitivity _____

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV _____ Self No Family

Allergies _____ Self No Family

Arthritis _____ Self No Family

Asthma _____ Self No Family

Autoimmune _____ Self No Family

Cancer _____ Self No Family

Diabetes _____ Self No Family

Ears, Nose, Throat Conditions _____ Self No Family

Gastrointestinal Conditions _____ Self No Family

Heart Disease _____ Self No Family

High Blood Pressure _____ Self No Family

High Cholesterol _____ Self No Family

Kidney Disease _____ Self No Family

Lupus _____ Self No Family

Neurological Conditions _____ Self No Family

Psychiatric Disorder _____ Self No Family

Seizures _____ Self No Family

Skin Conditions _____ Self No Family

Stroke _____ Self No Family

Thyroid Dysfunction _____ Self No Family

Vascular _____ Self No Family

Current Medications (prescription and over-the-counter) _____

_____

_____

_____

Medication Allergies _____

_____

Import Medication Consent: _____

SOCIAL HISTORY

Are you pregnant or nursing? _____ Yes No

Do you currently drive? _____ Yes No

Do you drink alcohol? _____ Yes No

Have you ever smoked? _____ Yes No

Do you currently smoke? _____ Yes No

For Office Use Only

Current Glasses:

OD: _____

OS: _____

Contact Lenses: Brand, Power, BC, Diam.

OD: _____

OS: _____

IOPs: OD: _____ mmHg OS: _____ mmHg **Temp:**_____ **[ ] Retinal Photos** **[ ] F/U:** _____