TODAY'S DATE _____/_____/_____ **PATIENT INFORMATION FORM – PLEASE PRINT** ☐ **NEW PATIENT** ☐ **EXISTING PATIENT**

NEW PATIENTS complete the entire form below. **EXISTING PATIENTS**, please fill in the 3 lines marked by *** and any information below that may have changed since your last visit.

***Patient Name:_____ M / F Date of Birth:____/_____/_____ Age _____
(First Name) (Last Name) (gender)

Address:_____ Occupation:_____
(Street) (city) (state) (zip)

Email: _____Cell Phone:_____Home Phone #:_____ **CONTACT PREFERENCE: (circle) EMAIL / TEXT / CALL**

INSURANCE INFORMATION (Please give staff BOTH your VISION AND MEDICAL INSURANCE CARDS so they can be scanned into your record

When was your last eye exam? _____ Doctor?_____ Do you wear glasses? **No** **Yes** Have you ever had an exam **at this location?** No Yes

***ARE YOU PLANNING ON BEING DILATED TODAY? NO / YES** Dilated Exam (eye drops required) is recommend. (may cause blur /light sensitivity / inability to drive initially /adds 30 minutes to exam) (Dilation is covered by Eyemed, Medicare, Blue Cross Medical) **If not covered by insurance there is a $40 additional fee.**
ASK OUR STAFF ABOUT HAVING AN OPTOMAP RETINAL EXAM AS AN ALTERNATIVE TO DILATION (NO DROPS REQUIRED)

CONTACT LENS PATIENTS ONLY: Are you here for your yearly Contact Lens Evaluation to RENEW **your** CONTACT LENS PRESCRIPTION**?** No Yes

The standard of care is to perform yearly contact lens exams to assess eye health and appropriate lens fit. The professional fee for these services are between $100 and $140 in addition to the exam fee. Rarely will insurance plans cover contact lens evaluations, contact lens fitting, and contact lenses.

YOUR Current EYE History (PSFH) (Check all that apply) ☐ Blurred Vision ☐ Burning ☐ Itching ☐ Dryness ☐ Tearing ☐ Floaters / Spots ☐ Flashes / Sparks

YOUR Past EYE History: ☐ Glaucoma ☐ Glaucoama Suspect ☐ Cataract ☐ Age related Macular Degeneration ☐ Surgery ☐ Patching ☐ Inflammatory disorder ☐ Strabismus ☐ Amblyopia ☐ Retinal Degeneration/ Hole / Detachment ☐ Keratoconus ☐ Injury ☐ Other_____

Do you drink alcohol? **No** **Yes** Amount_____ Do you use tobacco? **No** **Yes** Amount?_____

YOUR Health History: Review of Systems (Required by YOUR Insurance Company) (Circle all that apply)	
Constitution: Developmental Disability Cancer Fatigue Syndrome	**Gastrointestinal**: Crohn's Colitis Ulcer Acid reflux Celiac Disease
Ear, Nose, Throat: Hearing loss Sinusitis Dry Mouth Laryngitis	**Genitourinary:** Kidney disease Prostate disease STD Pregnancy Nursing
Neuro: MS Epilepsy Cerebral Palsy Tumor Stroke Migraine	**Musc/Skeletal:** Arthritis Fibromyal Musclar Dyst. Ankyl. Spond. Osteopor Gout
Psych: Depression ADD Anxiety Bipolar	**Integ (skin):** Eczema Rosacea Psoriasis Simplex/Cold sores Shingles
Cardiovasc: Hypertension Stroke Heart disease Vascular disease	**Endocrine:** Type 2 Diabetes Type 1 Diab. Thyroid Dysfunct. Hormonal Dysfunct.
Respiratory: Asthma Bronchitis Emphysema Obstruction Sleep Apnea	**Hem/lymph (blood):** Anemia XR of blood loss Ulcer High Cholestrol Infectious Disease
Other:_____	**Allergy / Imm:** Environ or Drug Allergy Rheumatoid Arthritis Sjogren's Lupus

List Current **MEDICATIONS**:_____

Reason for Meds (circle all that apply) Acid Reflux Allergy Antibiotic Anxiety Arthritis Asthma Birth Control Blood Thinner Chemo Cholesterol Depression Diabetes Insulin Diabetes Pills Gout High Blood Pressure Hormones Migraine Pain Prostate Thyroid Steroid /anti inflammatory Eye drops / antibiotic Eye drops / artificial tears Eyedrops / Glaucoma Eyedrops / allergy Other_____

ALLERGIES_____ NONE

FAMILY History: Medical and Ocular. Write dad, mom, bro, sis, son, daughter next to all that apply.	
Diabetes	Macular Degeneration
Hypertension	Glaucoma/Suspect
Thyroid	Retinal Detachment
Cancer	Amblyopia
Other	Strabismus
Cataract	Severe Myopia (Nearsightedness)

OFFICE POLICIES: Payment is expected at the time of visit. Professional fees are not refundable. There is a $20 returned check fee. Our office accepts many insurance plans and we are happy to accept assignment. Our staff will make every effort to obtain eligibility for you. However, there are times we cannot determine coverage due to factors beyond our control. You are expected to pay for your visit if coverage cannot be verified. **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.** If you are not eligible for benefits or are eligible for less than full coverage, **your signature indicates that you agree to be financially responsible for the balance not paid by your plan.**

***Patient / Guardian (if patient under 18) Signature_____ Date _____
EXISTING PATIENTS: My signature indicates that there have been no changes in my history/ medications/ allergies other than the changes that I indicated above.