Preferred Eye Care, LLC
Todd Fettig, OD
Christopher Kerby, OD
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www.preferred-eyecare.com

New Patient Information

Please review, make necessary changes and supply any missing information. **Date:**

Patient Name		**Date of Birth**	
Primary Care Physician		**Social Security Number**	
Last Eye Doctor		**Approximately when was your last eye exam**	

Review Of Systems	
Please list any current illnesses, symptoms or problems	
Cardiovascular (high blood pressure, heart disease, high cholesterol)	
Ears, Nose, Mouth, Throat	
Pulmonary (asthma, bronchitis, emphysema)	
Gastrointestinal (ulcer, colitis, reflux)	
Genitourinary (kidney, prostate)	
Bones / Joints / Muscles (arthritis, lupus, osteoporosis)	
Skin (psoriasis, shingles, skin cancer)	
Neurological (migraine, seizure, stroke)	
Psychiatric (anxiety, depression, bipolar, schizophrenia)	
Endocrine (diabetes, thyroid)	
Hematology (anemia, bleeding tendency, HIV/AIDS, hepatitis C)	
Allergic / Immunologic	
Other	

^fx.keepempty^Surgical Information				
Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Past / Present Ocular History		
Please list any past or present ocular illnesses, symptoms or problems		**Date Diagnosed**
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Diabetes		
Dry Eye		
Refractive		
Other		
Other		

Do you work on a computer?		**Hours per day**	

Social History	
What type of alcohol do you drink, how much and how often?	
Please check which one applies: □ **Current smoker – Packs per day _____** □ **Former smoker** □ **Never smoked**	
Occupation	
Hobbies	

Family History	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Glaucoma	
Cataracts	
ARMD	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	

Family History	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Heart Disease	
Hypertension	
High Cholesterol	
Kidney Disease	
Other	
Other	

Allergies			
Allergy	**Onset Date**	**Reaction**	**Severity**

Medications			
Please cross out any medications that you are no longer taking **Please list all prescriptions, over the counter and herbal medications**			
Date	**Name**	**Strength**	**Directions**

Contact Lens History				
Type of contact lenses you currently use (gas permeable, soft daily, extended)		**How often do you replace your contacts?**		□ **Daily** □ **Weekly** □ **Monthly**
Average number of hours that you wear your contacts		**Wearing Type** (daily, extended)		

Medical Alerts
Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI)

In order for Preferred Eye Care, LLC to provide healthcare to me, I understand that certain regulations require written authorization from me. I will provide Preferred Eye Care, LLC with the following permissions and authorizations:

1. I authorize release of information to other health care providers who may be consulted in the provision of health care to me.
2. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment and authorize payment of these benefits directly to Preferred Eye Care, LLC on my behalf. I authorize any holder of medical information about me to release to my insurance company and its agents to determine benefits payable.
3. There may be times when the doctor or staff memebers will need to contact me regarding appointments or other communications. In order to contact me, I authorize the following:

You may contact me on my: □ **Home phone** □ **Work phone** □ **Cell phone**

You may leave me a message on my: □ **Home phone** □ **Work phone** □ **Cell phone**

I authorize Preferred Eye Care, LLC to discuss my eye care with the following people:

_____

By signing below, I acknowledge that I understand if my circumstances should change, I am responsible for contacting Preferred Eye Care, LLC to make changes to these authorizations. I am personally responsible for my billing, including any amount not covered by my insurance. Should my insurance not cover services rendered, I am responsible for covering any unpaid balance. I acknowledge I will be responsible for collection cost, attorney fees, court cost and administrative fees in the event this account should be turned over to collections for non-payment.

Signature_____ **Date**_____