NEWVISION EYECARE

Patient Name:_____Date of Birth:_____

Street Address:_____

City: _____State:_____Zip:_____

Home Phone:_____Day Phone:_____Cell Phone_____

☑ Check preferred contact number

E-Mail Address:_____

Single_____Married____Divorced_____Widowed____Student____

EMERGENCY CONTACT

Name_____Phone Number_____

Relationship to patient_____

ACCOUNT RESPONSIBILITY: If the information for the responsible party is *different* from what is listed above, please complete the following:

Name_____

Street Address_____

City_____State_____Zip_____

INSURANCE INFORMATION

Primary Insurance Name_____Subscriber ID#_____

Subscriber's Name_____DOB_____

Relationship to Patient_____

Secondary Insurance Name_____Subsciber ID#_____

Subscriber's Name_____DOB_____

Relationship to Patient_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES:

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

_____ _____

Signature of Patient, Parent or Guardian Date

INSURANCE ASSIGNMENT:

I hereby authorize payment directly to the physician of the insurance benefit otherwise payable to me. I understand that I am responsible for all costs of vision care and that, in the absence of vision or medical insurance, **payment is due at the time of service**.

The guardian who brings in a child, or whom the child lives with, is ultimately responsible for all unpaid balances. I hereby authorize the doctor to administer such medications and perform diagnostic and therapeutic procedures as may be necessary for proper eye care.

_____ _____

Signature of Patient, Parent or Guardian Date

VISION AND GENERAL HISTORY

Date of your last exam (approximate)_____

Name of Eye Dr. or Clinic_____

Reason for having an eye exam today_____

Do you currently wear glasses ____Yes ___No Full Time_____ Part Time_____
Do you currently wear contacts____Yes ___No
If yes what Brand?_____

Do you want a contact lens exam today? _____Yes _____No
If yes…contact lens exam & fitting fees are not normally a covered benefit under most insurance plans. If you choose to be examined for contact lenses and/or need to be fit with a new prescription, you will be responsible for the professional services charges.

Do you have a history of any of the following?

	YES	**NO**
Blindness	_____	_____
Eye Turn (Strabismus)	_____	_____
Lazy Eye (Amblyopia)	_____	_____
Kerataconus	_____	_____
Macular Degeneration	_____	_____
Retinal Detachment	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____

Are you currently experiencing any of the following?

	YES	**NO**
Headaches	_____	_____
Blurred Vision	_____	_____
Double Vision	_____	_____
Eyes “hurt” or “tired”	_____	_____
Floaters	_____	_____
Flashing lights	_____	_____
Eyes feel sandy/gritty	_____	_____
Halos around lights	_____	_____
Bothered by light/sun	_____	_____
Frequent styes	_____	_____
Eyes frequently red	_____	_____
Eyes itch	_____	_____
Eyes tear	_____	_____
Eyes feel Dry	_____	_____

How many hours a day do you use a computer?
_____

Describe any visual symptoms from computer use:_____
_____

MEDICAL HISTORY/REVIEW OF SYSTEMS:

Physician's Name:_____

Please list all medications you are currently taking (including any over the counter vitamins):

_____

_____

Allergies: _____

Are you Pregnant and nursing? _____YES _____NO
If yes, what is the due/birth date? _____

Do you have, or ever had any CHRONIC problems in the following areas?

	YES	NO
Migraines	_____	_____
Multiple Sclerosis	_____	_____
Diabetes	_____	_____
Thyroid problems	_____	_____
Arthritis	_____	_____
Allergies/Hay fever	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
High Blood Pressure	_____	_____
Stroke	_____	_____
Anemia	_____	_____
Cancer	_____	_____

FAMILY HISTORY _____family history is unknown/adopted

Is there a history of any of the following in family members (parents, grandparents, siblings, children)?

	Yes	No	Relationship		Yes	No	Relationship
Poor Vision	___	___	_____	Cancer	____	____	_____
Blindness	___	___	_____	Diabetes	____	____	_____
Eye Turn (Strabismus	___	___	_____	High Blood Pressure	____	____	_____
Lazy Eye (Amblyopia)	___	___	_____	Stroke	____	____	_____
Kerataconus	___	___	_____	Thyroid Disease	____	____	_____
Glaucoma	___	___	_____	Heart Disease	____	____	_____
Cataracts	___	___	_____	Other Inherited Disease	____	____	_____
Macular Degeneration	___	___	_____	If yes what disease_____			
Retinal Detachment	___	___	_____				

SOCIAL HISTORY

How often do you smoke/use tobacco products? ____**Yes** ____**No**
How often do you consume alcohol?_____

Patient Name **Signature** **Date**