New Patient Welcome Form

Please bring a list of your medications with you to your appointment. We will also need to make a copy of your medical insurance card.

Patient's Name: _____ Date of Birth: _____ Sex: F M

Last 4 of Social Security #_____

If a Child, Parent's Name: _____ Parent's DOB: _____

Street Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____

Primary Insured Information:
Name: _____ DOB: _____ Last 4 SS# _____

Employer_____

Vision Insurance Co: _____ ID: _____ Group #_____

Medical Insurance Co.: _____ ID: _____ Group #_____

- ☐ **I wear glasses** ***(Please wear/bring to your appointment)***
- ☐ **I am a current contact lens wearer.** ***(Please wear contacts to your appointment. New patients please bring prescription information including powers and brand)***
- ☐ **I want to discuss becoming a new contact lens wearer with the doctor.**

- *To the best of my knowledge all information on this form and all verbal information given is correct.*
- *I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I also acknowledge that a complete Notice of Privacy Policy for this practice is available upon request.*
- ***Explanation of benefits is given as a courtesy to our patients, but is not a guarantee of coverage, benefits, or payment. I understand that I am financially responsible for all charges whether or not paid by insurance. If payment to this account becomes delinquent the account will be assigned to a collection agency.***
- ***There is a $25 fee for all returned checks.***
- ***There is a fee for missed appointments not canceled within 24 hours.***

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. A complete copy of The Notice of Privacy Practices document is available and describes these uses and disclosures in detail. I acknowledged that I have been offered the Notice of Privacy Practices.

Signature of patient (or guardian if patient is a minor) _____ Date_____

Relationship to Patient if patient is a minor _____

Please answer/fill out all of the following questions to the best of your ability.

Name: _____ DOB: _____ Today's Date _____

If other than at our office, approximate date of last eye exam: _____

What is the reason for this appointment? _____

Medical Doctor's Name _____

Personal Eye/Ocular History

Y / N Glaucoma type: dry wet onset
Y / N Cataracts
Y / N Cataract Surgery right eye date _____
Left eye date _____
Y / N Vision Corrective Surgery Type _____
Date _____
Y / N Other eye surgery _____
Y / N Amblyopia (lazy eye) which eye
Y / N Macular degeneration onset _____
Y / N Retinal tear/detachment
Y / N Eye Injury : please explain _____
_____
Y / N Color Vision Problems
Y / N Flashing lights Y / N Redness
Y / N Itching Y / N Burning
Y / N Tearing Y / N Dry

Family Eye/Ocular History

Condition	Relationship to Patient
Y / N Glaucoma	_____
Y / N Cataracts	_____
Y / N Macular degeneration	_____
Y / N Retinal detachment	_____
Y/ N Blindness	_____
Other: _____	_____

Personal Health History: Do you have any current problems with any of the following

- ☐ Allergic/Immunologic
- ☐ Blood/Lymph
- ☐ Cardiovascular
- ☐ Ear/Nose/Throat
- ☐ Gastrointestinal
- ☐ High Blood Pressure
- ☐ Endocrine (Glands)
- ☐ Diabetes (insulin dependent)
- ☐ Diabetes (non-insulin dependent)
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Nervous System
- ☐ Migraines/Headaches
- ☐ Seizure
- ☐ Stroke
- ☐ Respiratory
- ☐ Skin
- ☐ Cancer type _____
- ☐ Surgery What type & when _____
  _____

If you answered yes to any of these please explain date of onset, treatment, and symptoms.

Personal Social History:

Y / N Smoke circle daily use <1 pack 1-2 pack >2 packs
Y / N Drink Alcohol circle use:
occasional 1-2 day >3day
Y/ N Other substances
Y / N Hepatitis type _____ Y/ N HIV

List All Current Medications you are presently taking. Include non-prescription drugs.

List anything else that might help us treat you today.

List all **allergies** to **medications.**

Patient Consent for Use and Disclosure of Protected Health Information

Thurman Edward Wood, OD
4819 Calloway Drive Suite 101
Bakersfield, CA 93312
(661)325-7738

I hereby give my consent for Thurman Edward Wood, OD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Thurman Edward Wood, OD describes such uses and disclosures more completely.)
I have the right to review the Notice of Privacy Practices prior to signing this consent.
Thurman Edward Wood, OD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Pennie Wood
4819 Calloway Drive Suite 101
Bakersfield, CA 93312

With this consent Thurman Edward Wood, OD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
With this consent, Thurman Edward Wood, OD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
With this consent, Thurman Edward Wood, OD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Thurman Edward Wood, OD restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Thurman Edward Wood, OD to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Thurman Edward Wood, OD may decline to provide treatment to me.
Patient/guardian must be provided with a signed copy of this authorization form.

_____	_____	_____
Signature of Patient or Legal Guardian	Date	Relationship to Patient

_____	_____
Print Patient's Name	Print Name of Guardian if Applicable