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.**