NEW PATIENT MEDICAL & OCULAR HISTORY FORM

Date:

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ____

Preferred Name: ______________________ SS #: ______________________

Birth Date: ______________________ Age: ____________ Gender: ____________

Street: ______________________ City: ____________ State: ____ Zip: ________

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email: ______________________

Occupation: ______________________ Employer: ______________________

Vision Insurance Plan: ______________________ Medical Insurance Plan: ______________________

Responsible for Account: ____

Practice Policy / HIPAA

If you are using vision/medical insurance coverage for today's visit: I hereby authorize Associates In Eyecare, Optometrist, P. C., to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that any such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Please acknowledge that you have read/agreed to this statement.

Contact Lens Evaluation Fees: If you have insurance, your exam co-pay is for the Comprehensive Exam only. Wearing contact lenses is considered an elective form of vision correction, therefore the Contact Lens Diagnostic Evaluation is not covered and **you are responsible in full for this charge.** Some insurance plans do allow a certain reimbursement for the contact lenses IN LIEU OF glasses. I understand that there is an additional fee associated with the diagnostic evaluation of contact lenses whether I am a current contact lens wearer or new to contact lenses.

Returned Check Fee: All returned checks will incur a $25 processing fee.

I (name printed above) have been presented with the **Notice of Privacy Policy (HIPAA)** of Associates In Eyecare, Optometrist, P.C. and have been offered a copy of such policy for my records.

Visual Field & Digital Photography

Visual Field Test ☐ I accept ☐ I decline

Retina Photo ☐ I accept ☐ I decline

Associates in Eyecare
OPTOMETRISTS, PC

NEW PATIENT MEDICAL & OCULAR HISTORY FORM

Medical & Ocular History

Reason for today's visit: ☐ new glasses ☐ contact lenses ☐ dry eyes ☐ diabetic exam ☐ LASIK ☐ failed vision screening ☐ other ______________________

Please describe any concerns you have regarding your eyes, vision, ocular health or disease prevention:

____
____
____

Date of Last Eye Exam: ____________________ Doctor / Location: ____________________

Do you use or wear… comments *(blurry, clear, scratched, discomfort, no issues)*

Eyeglasses? ☐ no ☐ yes ______________________
Contact Lenses? ☐ no ☐ yes ______________________
Drug Store Readers? ☐ no ☐ yes ______________________

Please list all medications you currently take and why *(for example: Lipitor for cholesterol)*:

____
____
____

Are you…

Allergic to Medication? ☐ no ☐ yes ______________________
Pregnant or Nursing? ☐ no ☐ yes if yes, due date ______________________
Being Treated for: ☐ HIV ☐ Hepatitis ☐ Gonorrhea ☐ Syphillis ☐ Other ____________

Review of Systems

Ocular	Self	Family	Relation	Medical	Self	Family	Relation
Lazy eye	☐	☐	________	High blood pressure	☐	☐	________
Eye turn/wandering	☐	☐	________	Cholesterol	☐	☐	________
Color 'blind'	☐	☐	________	Diabetes	☐	☐	________
Light sensitivity	☐	☐	________	Thyroid	☐	☐	________
Eyestrain	☐	☐	________	Arthritis	☐	☐	________
Dry eyes	☐	☐	________	Gastro-intestinal	☐	☐	________
Floaters/spots	☐	☐	________	Respiratory	☐	☐	________
Retinal detachment	☐	☐	________	Cancer	☐	☐	________
Blindness	☐	☐	________	Headaches/Migraine	☐	☐	________
Cataracts	☐	☐	________	Head trauma	☐	☐	________
Glaucoma	☐	☐	________	Stroke	☐	☐	________
Eye injury/surgery	☐	☐	________	Neurological disorder	☐	☐	________

Patient Signature (parent/guardian if minor)	**Doctor Signature**	**Date**