NEW PATIENT

**PLEASE PRINT** Today's Date: _____

Name_____ M.I.____

Street_____

City _____

State _____ ZIP _____ Best # to Contact You

Phone: Home _____ ☐

Phone: Daytime _____ ☐

Phone: Cell _____ ☐

E-Mail Address_____

Date of Birth _____ Age_____

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Do you have children? Yes ☐ No ☐

Student? Yes ☐ No ☐

Employed? Yes ☐ No ☐ Retired ☐

Job Title _____

Employed by _____

Describe what you do _____

_____, Hobbies: _____

How did you find our office?

☐ Referred by _____

☐ Internet Search ☐ Received Mailing

☐ Insurance Website / List ☐ Found Our Website

☐ Saw Sign / Building ☐ Yellow Pages/Book

***Please note that your insurance benefits are based on a contract between you and your insurance company. Any disputes about your benefits are between you and them, not between you and us. Financial responsibility for co-payments and non-covered services or products remains with you. Full payment, less anticipated insurance coverage, must be received before materials are dispensed. If you have questions regarding your insurance, please call the member services department listed on your card or contact your Human Resources Department.***

**Vision Insurance:** ☐ Avesis ☐ BC/BS ☐ CIGNA

☐ Davis including FEP, GE, Highmark ☐ EyeMed

☐ Medicare ☐ Spectera ☐ Superior ☐ United Healthcare ☐ TriCare ☐ VBA ☐ VSP

☐ Amerigroup/OptiCare/PeachCare/WellCare

If you have Medicaid, do you have other health ins.? Y N

☐ Other: _____

Insured's Name: _____

Plan ID# or last 4 digits of SS#_____

Insured's Date of Birth: _____

Patient's Relationship to Insured: Self | Spouse | Child

**Medical Insurance:** _____

(For a medical eye problem please give card to receptionist)

**REASON FOR TODAY'S VISIT:**

☐ Routine Eye Examination ***and / or*:**

☐ Want New Glasses ☐ Want More Contacts

☐ Want Contact Lenses: 1st time

☐ Other: _____

_____

How long has it been since your last examination?

Date of or number of years _____

| | YES | NO |
|---|---|---|
| Do you wear eyeglasses? | ☐ | ☐ |
| If you wear contacts, do you have glasses? | ☐ | ☐ |
| Do you routinely wear sunglasses? | ☐ | ☐ |
| Do you smoke? | ☐ | ☐ |
| Do you use *any kind* of eye drops? | ☐ | ☐ |
| Any previous eye surgeries/injuries? | ☐ | ☐ |

What/When:_____

Do you have headaches? (# per week _____) ☐

Are you prepared to have your eyes dilated today?

☐ YES ☐ NO

Dilation helps the doctor see inside your eyes. The need for dilation depends on a number of factors including your age, your general health, the natural size of your pupils, and the length of time since your last dilation. The effects of dilation last 3-5 hours and include light sensitivity and distorted vision especially when reading.

* * * * * * * * * * * * * *

Check any that apply to you or a family member:

☐ Color Blind: who _____

☐ Glaucoma: who _____

☐ Macular Degeneration: _____

Check any health problems you are being treated for

☐ Diabetes using: Pills ☐ Insulin injections ☐

☐ Hypertension ☐ High Cholesterol

☐ Heart Problem _____ ☐ Cancer _____

☐ Arthritis ☐ Asthma ☐ COPD ☐ Allergies

☐ Anxiety ☐ Depression ☐ Kidney/Liver

If pregnant, how many months? _____

* * * * * * * * * * * * * *

**HIPPA NOTICE**

I have been presented with a copy of the Notice of Privacy Policies for Focus on Vision, understand them and when applicable, agree that they may submit information to my insurance company and receive payment from same for services rendered.

_____

Signature of Patient or Parent Date

**(TURN OVER TO OTHER SIDE)**

NEW PATIENT

List any prescription medications you are taking and what they are for:

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

List any Supplements or Vitamins you are taking:

_____

_____

_____

_____

_____

Are you allergic to any medications? No ☐ Yes ☐

_____

_____

_____

_____