Welcome to our office

eyecare & eyewear

New Patient Form

The doctors are genuinely concerned about our patients and they are prescribing a digital Optomap retinal scan with their regular eye exam to all patients. The digital scan will allow our doctors to view up to 97% of your retina without the need for dilation in most cases.

The retinal images will allow our doctors our doctors to identify the earliest signs of disease that might otherwise go undetected, such as: Macular Degeneration, Glaucoma, Diabetic Retinopathy, and Cancer of the eye. All of these can lead to blindness if left untreated. These scans may also reveal your risk for: Stroke, Hypertension or other systemic disease.

The procedure is painless and takes only a few moments to perform. The fee is $25 dollars and may not be covered by your insurance, but is an important part of your eye health exam.

Demographics ☐ Mr. ☐ Miss ☐ Mrs. ☐ Dr.

First Name ____ Last Name ____ MI ____ Nickname ____

Address ____ City ____ State/Zip ____

Home Phone ____ Work Phone ____ Other Phone ____

SS# ____--____--____ Email ____ DOB *mm* / *dd* / *yy*

Occupation ____ Sex: Male ☐ Female ☐ Marital Status ____

Employment Status: Employed ☐ Full Time Student ☐ Part-Time Student ☐

Employer/School Name ____

Misc/Guardian ____

[Type text]

Vision Insurance

Insurance Information

Insurance Name: ____

Insurance ID: ___________________________________ Insurance Policy Group: _______________________________

If you are **NOT** the Primary on this insurance, please check this box ☐ and complete the following:

Primary Insured's Information

Name: Last First MI

DOB: mm/dd/yyyy Sex: ☐ Male ☐ Female

Address:

City: State: Zip:

Phone # Employer/School:

Your Relationship to Insured: ☐ Spouse ☐ Child ☐ Other

Medical Insurance

Insurance Information

Insurance Name: ____

Insurance ID: ___________________________________ Insurance Policy Group: _______________________________

If you are **NOT** the Primary on this insurance, please check this box ☐ and complete the following:

Primary Insured's Information

Name: Last First MI

DOB: mm/dd/yyyy Sex: ☐ Male ☐ Female

Address:

City: State: Zip:

Phone # Employer/School:

Your Relationship to Insured: ☐ Spouse ☐ Child ☐ Other

Medical History

Section 1: *Visual History*

Briefly describe the main reason for having an examination today: ______________________________

____

Other eye issues or problems? [ ]

Glasses Wearers: I currently wear glasses: ☐ Full-time ☐ Part-time

If part-time, how often/when? [ ]

Contact Lens Wearers: I currently wear contacts: ☐ Full-time ☐ Part-time ☐ Soft ☐ Rigid Gas Permeable

If part-time, how often/when? [ ]

Current Brand: [ ] Are your lenses comfortable? ☐ Yes ☐ No

How old is your current pair? [ ] What is your replacement schedule? [ ]

What solution do you use? [ ]

Please list all eyedrops you use (OTC and Rx):	**How often used?:**

Do you have a history of any of the following? Are you currently experiencing any of the following?

	Yes	No
Blindness	☐	☐
Eye Turn (Strabismus)	☐	☐
Lazy Eye (Amblyopia)	☐	☐
Keratoconus	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

	Yes	No
Headaches	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Eyes *Hurt* or *Tired*	☐	☐
Eye pain or soreness	☐	☐
Halos around lights	☐	☐
Bothered by light/sunlight	☐	☐
Frequent styes	☐	☐
Eyes frequently red	☐	☐
Infection of eye or lid	☐	☐

	Yes	No
Itchy Eyes	☐	☐
Burning Eyes	☐	☐
Watery Eyes	☐	☐
Dry Eyes	☐	☐
Eyes feel sandy/gritty	☐	☐
Mucous Discharge	☐	☐
Floaters	☐	☐
Loss of Vision	☐	☐
Flashing Lights	☐	☐

How many hours a day do you use a computer? [ ] How far away from your eyes is your computer? [ ]

Describe any visual symptoms from computer use: [ ]

Medical History **Section 2:** ***Review of Systems***

Physician's Name: ____________ Last Visit Date: ____________

List all medications you are currently taking (including any OTC/vitamins)**:**

List any medications you are allergic to:

Are you pregnant or nursing? ☐ Yes ☐ No If yes, what is the due/birth date? ____________

Have you ever experienced problems in the following areas?

CONSTITUTIONAL
- ☐ Recent Fever
- ☐ Undesired Weight Loss
- ☐ Other

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Cholesterol
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Arrhythmias
- ☐ Vascular Disease

GASTROINTESTINAL
- ☐ Ulcers
- ☐ Intestinal Polyps
- ☐ Reflux Disease
- ☐ Cancer

INTEGUMENTARY (SKIN)
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Skin Cancer

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Parkinson's

IMMUNOLOGY/ALLERGY
- ☐ HIV
- ☐ Allergy to Metals

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Drug Dependence
- ☐ Alcoholism
- ☐ Bipolar or Schizophrenia

EAR/NOSE/THROAT
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Dry Mouth/Throat
- ☐ Hearing Loss

RESPIRATORY
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Cancer

MUSKULOSKELETAL
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Dysfunction
- ☐ Pituitary Dysfunction

HEMATOLOGIC/BLOOD
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Other

GENITOURARY
- ☐ Urinary Tract Infection
- ☐ Renal (Kidney) Failure
- ☐ Prostate/Ovarian

Medical History

Section 3: ***Family History***

Family history is unknown/adopted: ☐

Any history of the following in any family members (Parents, grandparents, siblings, children)?

	Yes	No	Relationship to Patient
Poor Vision	☐	☐	
Blindness	☐	☐	
Eye Turn (Strabismus)	☐	☐	
Lazy Eye (Amblyopia)	☐	☐	
Glaucoma	☐	☐	
Cataracts	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment Disease	☐	☐	

	Yes	No	Relationship to Patient
Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Other Inherited Disease	☐	☐	

If yes what disease?

Medical History

Section 4: ***Social History (Confidential)***

How often do you smoke/use tobacco products?:

How often do you consume alcohol?:

Do you have? ☐ Hepatitis ☐ HIV ☐ STDs ☐ None

Occupation:

Employer:

Medical History

Section 5: ***Referrals***

Who Referred you to *Insight Eyecare & Eyewear*?:

If not referred, how did you hear about *Insight Eyecare & Eyewear*? Please select:

☐ Insurance Listing ☐ Drive by ☐ Google ☐ Other

☐ Doctor or Family/Friend? ____________________

Please Read:

Insight Eyecare & Eyewear asks that the patient's portion is paid at the time services are rendered. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees.

Payment from my insurance is to be paid directly to Insight Eyecare & Eyewear. I understand that my primary insurance company will be billed and billing of any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my Insurance company and that final determination can only be made when the claim is processed.

I understand my rights regarding my records, and a copy of Insight Eyecare& Eyewear *Notice of Privacy Practices* has been made available to me. ***We kindly ask that you provide our office with 24 hour notice for all cancellations.***

Signature ____________________ Date: ____________________