New Patient Information

Welcome to our office! Please complete this questionnaire in full to help us better serve you!

First Name: _____ Last Name: _____Middle Initial: ___

Preferred Name: _____

Date of Birth: _____ Social Security Number: _____-_____-_____ Sex: M / F

Address: _____City_____ State_____ Zip_____

Phone Numbers: Home: _____Work: _____ Cell: _____

Employer: _____ Email address: _____

Marital Status: Single Married Widowed

Preferred Language: _____Race/Ethnicity: _____

Sexual Orientation: (Circle) Straight Heterosexual Bisexual No Answer

Gender Identity: _____ Need of Interpreter: Y / N

INSURANCE

Vision Insurance: _____ Policy # _____

Policy Holder's Name/Birthday/SS# : _____

Medical Insurance: _____Policy # _____

Policy Holder's Name/Birthday/SS# : _____

What are your visual symptoms today? Please check all that apply.

- o Blurry Vision
- o Burning
- o Floaters/Spots
- o Haloes
- o Double Vision
- o Itching
- o Flashes of Light
- o Eye Strain
- o Dry Eyes
- o Headaches
- o Eye Infection
- o Redness
- o Loss of Vision
- o Eye Pain
- o Watering/Discharge
- o Crossed Eye

Do you wear glasses? Y / N If so, how old are your current glasses? _____

Do you wear contact? Y / N Are you interested in contacts today? Y / N

Your brand of contact: _____ Contact Solution: _____

Replacement Schedule: Daily / 2 Week / Monthly / Yearly Wearing Schedule: Daily / Overnight

Have you ever had eye surgery? Y / N Type: _____ Which Eye? _____

Do you use eye medication? _____

PERSONAL MEDICAL HISTORY: Please check all that applies to YOU.

Constitutional
- o Developmental Disabilities
- o Cancer
- o Fatigue Syndrome

E/N/T
- o Hearing Loss
- o Sinusitis
- o Dry Mouth
- o Laryngitis

Neurological
- o Multiple Sclerosis
- o Epilepsy
- o Cerebral Palsy
- o Tumor
- o Stroke/CVA
- o Migraine
- o Autism

Psychiatric
- o Depression
- o Attention Deficit
- o Anxiety
- o Bipolar

Cardiovascular
- o High Blood Pressure
- o Stroke/CVA
- o Heart Disease
- o Vascular Disease
- o Congestive Heart Failure

Respiratory
- o Asthma
- o Bronchitis
- o Emphysema
- o Chronic Obstruction
- o Sleep Apnea

Gastrointestinal
- o Crohn's
- o Colitis
- o Ulcer
- o Acid Reflux
- o Celiac Disease

Genitourinary
- o Kidney Disease
- o Prostate Disease
- o STD
- o Prostate Hypertrophy
- o Pregnant
- o Nursing

Musculoskeletal
- o Arthritis
- o Osteoarthritis
- o Fibromyalgia
- o Muscular Dystrophy
- o Ankylosing Spondylitis
- o Osteoporosis

Integumentary
- o Eczema
- o Rosacea
- o Psoriasis
- o Cold Sores
- o Shingles

Endocrine
- o Diabetes Type I
- o Diabetes Type II
- o Thyroid Dysfunction
- o Hormonal Dysfuntion

Hemotologic/ Lymphatic
- o Anemia
- o Large-Vol blood loss
- o Ulcer
- o High Cholesterol

Allergic/Immune
- o Environmental Allergies
- o Rheumatoid/Arthritis
- o Lupus
- o Sjogren's Syndrome

Other: _____

Current Medications: _____

_____

Drug Allergies: _____

Your Pharmacy: _____

Alcohol Use: Y / N Amount: _____ Tobacco Use: Y / N Amount: _____

FAMILY HISTORY: Answer for immediate family members (parents/siblings)

- Retinal Detachment
- Blindness
- Cataracts
- Glaucoma
- Crossed Eyes
- Macular Degeneration
- Other Eye Diseases
- Diabetes
- High Blood Pressure
- Cancer
- Heart Disease
- High Cholesterol

INSURANCE: I, the undersigned, authorize payment of medical benefits to the physician for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize 2020 Eyecare to release information to my insurance company concerning healthcare, advice, treatment, or supplies provide to me. This information will be used for the purpose of evaluating and administering claims and benefits.

LIFETIME SIGNATURE: _____ DATE: _____

MEDICARE: I agree to be responsible for my deductible and/or any uncovered charge as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made on my behalf to this physician for any services furnished to me by this physician. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration and its agents to determine benefits or benefits payable for related services.

LIFETIME SIGNATURE: _____ DATE: _____

MEDICAID: I agree to be responsible for any services not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this physician. I authorize any holder of medical or other information about me to be released to the Division of Medicaid or its Fiscal Agent or any information needed to determine these benefits payable for related services.

LIFETIME SIGNATURE: _____ DATE: _____

OFFICE POLICY ON PAYMENT: I understand that I am responsible of all charges. As a courtesy, if applicable, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any remaining balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that I am responsible for my deductible and any portion not covered by my insurance at the time services are rendered. I further agree that should the account become delinquent and require collection efforts, I agree to pay the cost of collections, including reasonable attorney's fees and collections agency fees. I also understand there is a $30.00 fee for any returned checks for insufficient funds.

LIFETIME SIGNATURE: _____ DATE: _____

VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit/ per patient and that the vision plan to be used must be chosen BEFORE the exam occurs and CANNOT change at a later date.

_____ _____

PRINTED NAME OF PATIENT OR REPRESENTATIVE DATE

_____ _____

SIGNATURE RELATIONSHIP TO PATIENT

20/20 Eye Care

Acknowledge of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Date of Birth: _____

Any physician, staff, employee o representative of 20/20 Eye Care has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons to facilitate and coordinate my care, treatment, and payment.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to 20/20 Eye Care or complete a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

_____ _____

Patient or Guardian's Signature Date