NEW PATIENT FORM

How did you hear about us? ______________________

Date____________

Patient's Full Name ____ Sex _____

Parent's Name (if a child) ___________________________________

Name You Prefer to be Called ____________________ Birth Date ___________ Age _____

Street Address _____________________________ Primary Phone # _________________

City St Zip ________________________________ Alternate Phone # _________________

Email Address ____

Employer ____________________________ Occupation _______________________

Type of Visit Today:

Complete Exam for Glasses Only ____ Complete Exam for Contact Lenses and Glasses ____

Brief Medical Visit for Specific Eye Problem or Injury ____

Do you have insurance that will cover this visit? _____

Name of Vision Insurance ____________________________

Name of Medical Insurance __________________________

Insured's Full Name ________________________________ Insured's Birth Date _________

Patient's Relationship to Insured: Self ____ Spouse ____ Child ____ Other _____

My records may be released to/discussed with ________________________________

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please answer all questions.

NAME: ______________________ Today's Date: ______________
AGE: ______________________ DATE OF BIRTH: ______________

MEDICAL INFORMATION

Do you have problems with any of these systems? (Please **circle yes or no.)**

DIABETES	Yes / No	GASTROINTESTINAL	Yes / No
HIGH BLOOD PRESSURE	Yes / No	EARS/NOSE/THROAT	Yes / No
HEART DISEASE	Yes / No	CARDIOVASCULAR	Yes / No
ARTHRITIS	Yes / No	RESPIRTORY	Yes / No
CANCER	Yes / No	GENITOURINARY	Yes / No
DERMATOLOGIC	Yes / No	KIDNEY STONES	Yes / No
STEROID USE	Yes / No	BLOOD/LYMPH	Yes / No
HEADACHES	Yes / No	OTHER ILLNESS	Yes / No

Allergies to Medications: Yes / No Please List: ______________________

____

Current medications please List: ______________________

____

Eye Medications: ______________________

Do you use Alcohol? Yes / No How much in one week? ______________
Do you use Tobacco? Yes / No How much in one week? ______________

FAMILY HISTORY

High blood pressure	Yes / No	Relation ______________
Diabetes	Yes / No	Relation ______________
Macular degeneration	Yes / No	Relation ______________
Glaucoma	Yes / No	Relation ______________
Retinal detachment	Yes / No	Relation ______________
Cataracts	Yes / No	Relation ______________
Blindness	Yes / No	Relation ______________
Other	Yes / No	Relation ______________

PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind? ______________ Date ________
Have you had any eye operations? Yes/No What Kind? ______________ Date ________
(Please circle.)
Do you have Glaucoma? Cataracts? Retinal detachment? Macular degeneration?
Dry Eyes? Blurred Vision? Lazy Eye/Crossed Eye
Do you wear glasses? Yes/No Do you wear Contacts? Yes/No

UPDATED ______________
UPDATED ______________

PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind?________________ Date_______

Have you had any eye operations? Yes/No What Kind? ________________ Date_______

Do you wear glasses? Yes/No

Do you wear Contacts? Yes/No

Have you ever had any of the following **(please circle):** Cataracts, Glaucoma, Retinal Detachment, Macular degeneration, Crossed Eyes, Lazy eye, Drooping eyelid, Prominent eyes

Do you currently, or have you ever had any problems in the following areas:

Loss of Vision	**No**	**Yes**
Blurred Vision	**No**	**Yes**
Distorted Vision/Halos	**No**	**Yes**
Loss of Side Vision	**No**	**Yes**
Double Vision	**No**	**Yes**
Dryness	**No**	**Yes**
Mucous Discharge	**No**	**Yes**
Redness	**No**	**Yes**
Sandy or Gritty Feeling	**No**	**Yes**
Itching	**No**	**Yes**
Burning	**No**	**Yes**
Foreign Body Sensation	**No**	**Yes**
Excess Tearing/Watering	**No**	**Yes**
Glare/Light Sensitivity	**No**	**Yes**
Eye Pain or Soreness	**No**	**Yes**
Chronic Infection of Eye or Lid	**No**	**Yes**
Sties or Chalazion	**No**	**Yes**
Flashes/Floaters in Vision	**No**	**Yes**
Tired Eyes	**No**	**Yes**

UPDATED__________________

UPDATED__________________

Patient Acknowledgments

Insurance

Please present all insurance cards prior to your examination. We will inform you if we are an in-network provider for your insurance carrier. If we accept your insurance you are still responsible for copays, non-covered charges (i.e. refractions and/or contact lens fittings), and deductibles.

If you have had an insurance change since your last visit, you must notify us or you will be responsible for all services rendered.

If your insurance denies payment for any reason, you will be responsible for all services rendered.

Patients without insurance are expected to pay in full at the conclusion of your examination.

Authorization for Assignment of Benefits and Release of Information

I hereby authorize direct payment of my insurance benefits to the doctor/optical shop and authorize the release of any medical information necessary for the filing of insurance claims. I agree to be responsible for any amounts not paid by my insurance provider. This authorization is to remain valid for any or all services provided to me or my dependents by this office today or in the future.

______________________________ ______________

Signature of Patient or Responsible Party **Date**

HIPAA Privacy Policy

I acknowledge that I have been offered the HIPAA Privacy Policy and understand that the doctors and staff will not share my health information other than what is allowed by HIPAA.

______________________________ ______________

Signature **Date**

Consent to Contact

I hereby give consent for the staff of Auburn Eye Care to contact me by phone call, text, or email for the purpose of recall, insurance or payment issues.

______________________________ ______________

Signature **Date**