Our objective is to provide you the best of vision care. To do this, it is necessary that we know everything we can about your eyes. This includes your seeing needs and present health condition. Please answer all questions about your vision. What may seem a silly answer to you might be the very thing that will make your problem clearer to us so we can help you to attain eye comfort and visual efficiency.

Name: _____ DOB: _____

Nickname/Preferred Name: _____ Preferred Pronouns: _____

Address: _____ Zip: _____

City, State: _____ Occupation: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Work Phone: _____

Parent's Name (if a minor): _____ Parent's Phone: _____

If in school, what grade/level? _____

How did you hear about us?

Website □ Insurance □ Online □ Other □

If referred by a person or healthcare provider, whom may we thank?

_____

Insurance Information (please fill out completely)

We provide the service of billing your insurance company for you. Your co-payment (the portion of your bill that is not covered by insurance) is expected to be paid in full on the date of service.

Name of **Primary** Insured: _____

Primary's Date of Birth: _____ Primary's Last 4 Digits of SSN: _____

Insurance Company: _____ Phone: _____

Address: _____

City, State, Zip: _____

ID #: _____ Group #: _____

I authorize payment of benefits to my physician. I agree to be personally responsible for payment of all services rendered not covered by my insurance company. Also, by signing below, I acknowledge receiving the Notice of Privacy Practices.

Signature: _____ Date: _____

Most Recent Eye Exam:

Date: _____

Doctor: _____

Optometrist ☐

Eye Surgeon (Ophthalmologist) ☐

Do your parents/grandparents have any of the following:

Yes	No	
		Macular Degeneration?
		Glaucoma?
		Diabetes?

Do you have, or have you ever had, any of the following:

Yes	No	
		Heart Problems?
		High Blood Pressure?
		Diabetes?
		Thyroid Problems?
		Head or Eye Trauma?
		Glaucoma?
		Double Vision?
		Cataracts?
		Retinal Detachments?
		School Achievement Problems?

For What Purpose is Today's Visit:

Yes	No	
		Is this a periodic checkup?
		A medical issue?
Are you interested in:		
		Contact Lenses?
		Glasses or Sunglasses?
		Vision Therapy?
Other Information—Have you ever had:		
		Your eyes dilated?
		Any type of refractive surgery?

Are you taking any medications? If yes, please list: _____

_____

Please list any medications to which you are allergic: _____

What type of sports/activities do you do? _____

Are you satisfied with your current pair of glasses? (circle) Y / N

If not, what would you change about them? _____

How many hours are you on the computer each day? _____

Do you wear contacts (circle)? Yes / No Soft / Hard

How often do you change out your disposable lenses? _____

Do you sleep in your contacts? Y / N

What lens cleaning solution do you use? _____

How may we contact you?

Email_____

Text message/ cell number:_____

Release of Verbal Medical Information

Patient Name: _____ Date of Birth: _____

A New Vision restricts the release of protected health information (PHI) to that permitted by patient confidentiality laws. According to HIPAA regulations, permitted reasons for the release of PHI include treatment, payment, and healthcare operations, or as otherwise allowed by the specific signed authorization of patient or authorized personal representative.

The purpose of this Release of Verbal Medical Information form is to provide our patients an opportunity to permit verbal release of PHI in the following two (2) ways.

I. Permission to Verbally Discuss PHI with Family Members/Caregivers or Attorneys

I hereby authorize the providers and personnel of A New Vision to discuss my protected health information with the following person(s):

Name/Phone Number: _____ Relationship: _____

Name/Phone Number: _____ Relationship: _____

Name/Phone Number: _____ Relationship: _____

Name/Phone Number: _____ Relationship: _____

Name/Phone Number: _____ Relationship: _____

-or- ☐ **I decline.** Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

I. Permission to Leave a detailed message:

I hereby authorize medical providers and personnel of A New Vision to leave a detailed message at the following **phone number**: _____ and/or **e-mail**: _____

- This authorization will expire 1,095 days (3 years) from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such a revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.
- This form is not valid unless signed and dated.

_____ _____

Signature of Patient/Personal Representative Name of Patient/Personal Representative

_____ _____

Date Relationship to Patient