Associates in Eyecare
OPTOMETRISTS, PC

NEW PATIENT MEDICAL & OCULAR HISTORY FORM

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ SS#: _____

Birth Date: _____ Age: _____ Gender: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer/School: _____

How did you hear about us: _____

Medical Insurance Information

Medical Insurance Plan: _____ Member ID: _____

Phone Number: _____ Vision Ins. Plan: _____

Account Responsible Information ☐ Check box if patient is acct responsible

Last Name: _____ First Name: _____ MI: _____

Street: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Relationship to Patient: _____

SS#: _____ ****Please be sure to provide us with a copy of your medical insurance card.**

Practice Policy/HIPAA

If you are using vision/medical insurance coverage for today's visit: I hereby authorize Associates In Eyecare Optometrist, P.C., to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that any such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Please acknowledge that you have read/agreed to this statement.

Contact Lens Evaluation Fees: If you have insurance, your exams co-pay is for the Comprehensive Exam only. Wearing contact lenses is considered an elective form of Vision correction, therefore the contact lens Diagnostic Evaluation is not covered and **you are responsible in full for this for this charge.** Some insurance plans do allow a certain reimbursement for the contact lenses in LIEU OF glasses. I understand that there is an additional fee associated with the diagnostic evaluation of contact lenses whether I am a current contact lens wearer or new to contact lenses.

Retuned Check Fee: All returned checks will incur a $25.00 processing fee.

I (name printed above) have been presented with the Notice of Privacy Policy (HIPAA) of Associates In Eyecare, Optometrists, P.C. and have been offered a copy of such policy for my records.

Patient Signature (parent/guardian if minor)	Date

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Medical & Ocular History

Reason for today's visit: ☐ new glasses ☐ contact lenses ☐ dry eyes ☐ diabetic exam ☐ LASIK
☐ failed vision screening ☐ other _____

Please describe any concerns you have regarding your eyes, vision, ocular health or disease prevention:

_____

_____

_____

Date of Last Eye Exam: _____ Doctor / Location: _____

Do you use or wear… comments *(blurry, clear, scratched, discomfort, no issues)*

Eyeglasses?	☐ no	☐ yes	_____
Contact Lenses?	☐ no	☐ yes	_____
Drug Store Readers?	☐ no	☐ yes	_____

Please list all medications you currently take and why *(for example: Lipitor for cholesterol)*:

_____

_____

_____

Are you…

Allergic to Medication?	☐ no	☐ yes	_____
Pregnant or Nursing?	☐ no	☐ yes	if yes, due date _____

Being Treated for: ☐ HIV ☐ Hepatitis ☐ Gonorrhea ☐ Syphillis ☐ Other _____

Review of Systems

Ocular	Self	Family	Relation
Lazy eye	☐	☐	_____
Eye turn/wandering	☐	☐	_____
Color 'blind'	☐	☐	_____
Light sensitivity	☐	☐	_____
Eyestrain	☐	☐	_____
Dry eyes	☐	☐	_____
Floaters/spots	☐	☐	_____
Retinal detachment	☐	☐	_____
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Eye injury/surgery	☐	☐	_____
Macular Degeneration	☐	☐	_____

Medical	Self	Family	Relation
High blood pressure	☐	☐	_____
Cholesterol	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid	☐	☐	_____
Arthritis	☐	☐	_____
Gastro-intestinal	☐	☐	_____
Respiratory	☐	☐	_____
Cancer	☐	☐	_____
Headaches/Migraine	☐	☐	_____
Head trauma	☐	☐	_____
Stroke	☐	☐	_____
Neurological disorder	☐	☐	_____

Patient Signature (parent/guardian if minor)	**Doctor Signature**	**Date**