



Date: _____

NEW PATIENT FORM

GENERAL INFORMATION

Payment is due at the time of your examination. Please do not ask to be billed for professional services.

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

Nickname: _____ Birthdate: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____ Employer: _____

When was your last exam: _____ By whom? _____

or how did you find us? ☐ Drive by ☐ Google ☐ Facebook ☐ Other Website: _____



RESPONSIBLE PERSON (for Financial Statement) ☐ Same as above

Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

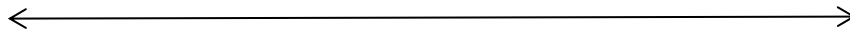
Name of Responsible Person: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____



INSURANCE INFORMATION

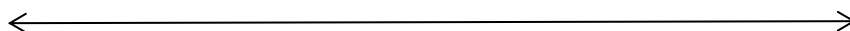
Please note that insurance may NOT cover all services in their entirety. All co-pays are due on day of service.

Vision Insurance: _____ Subscriber Name: _____

Subscriber SSN/ID#: _____ Subscriber SSN: _____

Subscriber Birth Date: _____ Subscriber Birth Date: _____

Primary Medical Insurance: _____ Secondary Medical Insurance: _____





AARA INFORMATION

Due to changes in healthcare privacy and healthcare reform laws, we are now required to gather certain information regarding your race and ethnicity. This information is required as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

PRIMARY LANGUAGE PREFERENCE (select one)

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Other _____

RACE (select one)

- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Declined to specify

ETHNICITY (select one)

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Declined to answer



HEALTH HISTORY QUESTIONNAIRE

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

Age: _____ Height: _____ Weight: _____

What is the reason for your visit today? _____

MEDICATIONS

List your medications (include oral contraceptives, aspirin, over the counter medications and home remedies). We are happy to photocopy your list:

Do you have any allergies to medication or medical devices? (If YES, please explain):

☐ Yes ☐ No _____

CONTACT LENS USERS ONLY

Please bring your current contact lens prescription or your contact lens box (for each eye if different).

What kind of contacts do you wear?

☐ Soft Disposable ☐ Gas Permeable

☐ Extended Wear ☐ Ortho K

May we request information from your previous

doctor? ☐ No ☐ Yes

Which contact lens solution do you use?

Do you have a backup pair of glasses?

☐ No ☐ Yes

Please bring your glasses with you to the appointment.

SOCIAL HISTORY

Please list usage or leave blank if not applicable.

☐ Tobacco _____ ☐ Alcohol _____ ☐ Drugs _____ ☐ I would prefer to discuss with my doctor

MISCELLANEOUS

Are you interested in learning more about...

☐ Refractive surgery options ☐ Corneal molding ☐ Are you pregnant or nursing? ☐ YES ☐ NO



Review of Systems

CARDIOVASCULAR	YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
.....medicated?	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
.....medicated?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL		
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Joint & Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>

EYES		
Corneal Transplant	<input type="checkbox"/>	<input type="checkbox"/>
PRK	<input type="checkbox"/>	<input type="checkbox"/>
LASIK	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL		
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
with Aura	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC		
ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	

IMMUNOLOGIC		
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
..... Plaquenil?	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	

HEMATOLOGIC/ LYMPHATIC		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL	YES	NO
Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY		
Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
..... Type 1	<input type="checkbox"/>	<input type="checkbox"/>
..... Type 2	<input type="checkbox"/>	<input type="checkbox"/>
..... Last A1C	<input type="checkbox"/>	<input type="checkbox"/>
..... Last Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism/ Graves (overactive)	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism (underactive)	<input type="checkbox"/>	<input type="checkbox"/>
Hashimotos Thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome (P.C.O.S)	<input type="checkbox"/>	<input type="checkbox"/>

SKIN		
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
..... medicated?	<input type="checkbox"/>	<input type="checkbox"/>
Albinism	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	

EAR, NOSE, MOUTH THROAT		
Allergies- nasal	<input type="checkbox"/>	<input type="checkbox"/>
Allergies- eyes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>



HEALTH SCREENING PHOTOS

WHAT ARE EYE HEALTH SCREENING PHOTOS?

This is one of the newest technologies for helping doctors manage the health of the eye. Wide-field, high definition, digital retinal photography allows us to examine, evaluate, and document the retina and the optic nerve.

The retina is the tissue in the back of the eye that is responsible for vision and the optic nerve is the structure that is responsible for transmitting the visual information from the retina to the brain.

WHAT THINGS CAN YOU SEE WITH RETINAL PHOTOGRAPHY?

Retinal photography is extremely useful in detecting eye diseases such as glaucoma, macular degeneration, and retinal disorders, as well as detecting signs of systemic diseases like diabetes and hypertension (high blood pressure).

WHO NEEDS THIS TEST?

Even though many of these eye conditions affect adults, retinal screening photography is recommended for all patients, including children. Retinal photos are helpful in identifying past eye injuries and provide a baseline for monitoring changes in or progression of future eye disorders. The doctors strongly recommend this test for all patients annually.

HOW DOES RETINAL PHOTOGRAPHY WORK?

Retinal photography is easy, comfortable, and takes only a few minutes. Most images can be captured without using dilating drops and can be viewed immediately by the doctor and patient.

Retinal images are stored digitally and are kept as part of your record. The images can be compared year after year at your annual eye examination.

HOW MUCH DOES IT COST?

The fee is \$39.00 for both eyes.

**EARLY DETECTION AND TREATMENT OF EYE DISEASE IS CRITICAL IN
PRESERVING VISION FOR A LIFETIME!**

- ☐ Yes, I choose to have this test performed at this time.
- ☐ No, I choose to defer this test at this time.
- ☐ I prefer to discuss with the Doctor prior to the test.

Patient's signature: _____ Date: _____
(parental signature needed if under age of 18)