New Patient Forms

Name:______________________________________ Date: ___________________
Address: ___________________________________ Home # _________________
City, Zip:___________________________________ Work # ________________
Email: _____________________________________ Cell # _________________
Communication Preference (circle): Email Phone Text D.O.B: __________________
Social Security # _____________ Marital Status:________ Race/Ethnicity:____________
Employment Status:____________ Employer:________________ Occupation:______________

How were you referred to our office? ☐ Friend/Physician:_________________________
☐ Google ☐ Yelp ☐ Facebook ☐ Office Website ☐ Other: ___________________________

Do you wear glasses ☐ No ☐ Yes Do you wear contacts ☐ No ☐ Yes
Are you interested in contacts ☐ No ☐ Yes Are you interested in Lasik ☐ No ☐ Yes

Policy & Procedures

Contact Lens Prescriptions:

A contact lens evaluation is always a separate fee from your comprehensive eye examination. Contact lens evaluations include additional testing to measure the curvature and health of your eyes. Contact lens prescriptions are valid for only one year by law. Contact lens fees vary according to the complexity of the contact lens fit and type of lenses used.

Dilation/Digital Fundus Photography Release Of Liability Authorization:

We at Advanced Family Eye Care urge that you have the back of your eye tested annually. This allows us to check for macular degeneration, glaucoma and diabetes. You can chose to have your eyes dilated at no additional cost, side effects will include blurriness and light sensitivity for up to 4 hours. This will also add an additional 20 minutes to your exam. Or you may have a digital photo taken for a fee of $20. This is a much quicker and safer method because there are no drops or side effects.

Dilation: Yes / No Digital Fundus Photo: Yes / No Initial:_________ Date:___________

Financial Agreement and Policy:

I understand that I'm fully responsible for the total cost of payment for all procedures and services performed at this office. I agree to pay my balance in full at the time of services, this includes unmet deductibles and co-pays. We do require a 50% deposit on any optometric materials before an order can be placed. Deposits for materials not picked up within 90 days may be forfeited without refund. In our continued commitment to provide excellent and convenient service, we will first apply any insurance benefits to the best of our ability. We also take most payment options including Care Credit.

Sign:____ Date:______________

Receipt of Notice of Privacy Policies & Consent Form (Laminated Form):

I have read and understood the Notice of Privacy Practices from Advanced Family Eye Care. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations.

Sign:____ Date:______________

Medical History

Are you pregnant and or nursing? □ No □ Yes

Have you ever been exposed to or infected with?□ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Do you have any allergies to medications? □ No □ Yes

List:______________________________

Do you take medications? □ No □ Yes

List:______________________________

Have you had any major injuries, hospitalizations or surgeries? □ No □Yes

List:______________________________

Do you have any eye conditions? □ No □ Yes

List:______________________________

Family History

Please check all conditions that apply. (parents,siblings, maternal/paternal grandparents and children: living or deceased)

Macular Degeneration □__________ Glaucoma □ __________

Retinal Detachment □__________ Diabetes □__________

High Blood Pressure □__________ Cancer □__________

Heart Disease □__________ Arthritis □__________

Note:______________________________

Social History

Do you smoke? □ No □ Yes If yes, amount / how long:__________

Do you drink? □ No □ Yes If yes, amount / how long:__________

Do you use narcotics? □ No □ Yes If yes, please define:__________

Review of Systems

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

Ears, Nose, Mouth, Throat	□ Allergies/Hayfever	□ Sinus Congestion	□ Runny Nose
	□ Post Nasal Drip	□ Chronic Cough	□ Dry Throat / Mouth
Constitutional	□ Fever	□ Extreme Weight Loss / Gain	
Neurological	□ Headaches	□ Migraines	□ Seizures
Endocrine	□ Thyroid / Other Glands		
Genitourinary	□ Genitals / Kidney / Bladder		
Gastrointestinal	□ Diarrhea	□ Constipation	
Bones / Joints / Muscles	□ Muscle Pain	□ Arthritis	□ Joint Pain
Respiratory	□ Asthma	□ Emphysema	□ Chronic Bronchitis
Vascular / Cardiovascular	□ Diabetes	□ High Blood Pressure	
	□ Heart Pain	□ Vascular Disease	
Lymphatic / Hematologic	□ Anemia	□ Bleeding Problems	

□ **Integumentary (Skin)** □ **Allergic / Immunologic** □ **Psychiatric**