

WELCOME

Name: _____ M / F Phone: _____

Address: _____ Cell: _____

City, State, Zip _____ Work Phone: _____

Social Security#: _____ Birth Date: _____ Age: _____ Spouse's Name: _____

Occupation: _____ Employer: _____

Medical Dr.: _____ Phone: _____ Last Visit: _____

Previous Eye Dr.: _____ Phone: _____ Last Visit: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How were you referred to our office: _____

Reason for visit today: _____

Medical History

Do you take any medications or supplements? NO / YES: (please list)

Do you use a breathing machine at night?: NO / YES type: _____

Are you allergic to any medications?: NO / YES: _____

Are you pregnant and/or nursing? NO / YES If yes, how far along: _____

Do you wear glasses? NO / YES If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? NO / YES If yes, how old is your present pair of lenses? _____

Type of contact lenses: (circle) Rigid Soft Extended wear Disposable Other: _____

Have you had any **eye** surgeries? NO / YES If yes, what, which eye and when: _____

Have you had any other surgeries? NO / YES If yes, what and when: _____

Do you work on a computer?: NO / YES If yes, how many hours a day: _____

Ocular/Medical History

Please note if **you and/or anyone** in your family has a history of the following conditions:

DISEASE/CONDITON	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History *This information is kept strictly confidential, however you may discuss this portion directly with your doctor if you prefer.*
 Yes, I would prefer to discuss my social history information directly with my doctor. (check box)

Do you drive? NO / YES If yes, do you have visual difficulty when driving? NO / YES If yes, please explain: _____

Do you use tobacco products? NO / YES If yes, type/amount/how long: _____

Do you drink alcohol? NO / YES If yes, type/amount/how long: _____

Do you use illegal drugs? NO / YES if yes, type/amount/how long: _____

Review Of Systems

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

SYSTEM	NO	YES	?		NO	YES	?
VASCULAR/CARDIOVASCULAR				NEUROLOGICAL			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what: _____			
EARS, NOSE, THROAT, MOUTH				ENDOCRINE			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid			
RESPIRATORY				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL				ALLERGIC/IMMUNOLOGIC			
Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A B C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY				HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BONES/JOINTS/MUSCLES				Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex/Zoster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY				Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER Type/Treated:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____				Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____				Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC				Excess Watering/Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If you answered YES to any of the above or have a condition not listed please explain:

Patient Signature: _____

Date: _____

Financial Policy/Insurance Agreement

VISION INSURANCE:

Insurance: _____ Policy Holder: _____

I.D.#: _____

MEDICAL INSURANCE:

Insurance: _____ Policy Holder: _____

I.D.#: _____

PAYMENT POLICY: If we are a participating provider in your insurance company plan, any co-pay, overage, or any other balance not paid by your insurance is required at the time of service. Payment for any materials such as glasses or contacts is due upon receipt of those materials, a deposit is required on glasses upon ordering.

PLEASE HELP US HELP YOU! It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding their own insurance policy. The insurance contract is between you and the insurance company NOT the physician and the insurance company. Our fees are not contingent on insurance allowances or slow payment and the patient is ultimately responsible to assure fee payment personally or by the insurance company. It is necessary that you provide us with your most current insurance card so we may keep a copy of it on file. Without an insurance card we may be unable to file a claim. We will not re-file a claim if the information given to us was incorrect. When purchasing materials such as glasses or contact lenses we must have the correct insurance information when an order is being placed. If you are picking up materials and the proper insurance information was not given to us at the time of the order it is your responsibility to file the claim privately.

PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE.

Do we need to update any changes in your name, address, phone numbers or insurance coverage?

The following is a list of insurances we accept: for **ROUTINE AND/OR MEDICAL:** MEDICARE, CIGNA (although some Cigna plans are MD only plans), UNITED HEALTH CARE, GREAT-WEST, HUMANA, VSP, SPECTERA.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARDS TO PAYMENT OF FEES FOR SERVICES RENDERED BY THIRD AVENUE EYECARE. In the event that I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable collection fee of up to 30% of the principal balance for any debt incurred hereunder and to pay all reasonable attorney fees and court cost as a result of my default.

SIGNATURE

DATE