Patient Information

Date: _____ SS# _____

Race: _____ Preferred Langage _____

***If English is NOT your preferred language, can you speak and understand it? Yes No

Patient Name: _____ male [] female []

Date of Birth _____ Age: _____

Address: _____

_____

City: _____

State: _____ Zip: _____

If we may contact you by e-mail please enter below:

e-mail: _____

Phone Numbers

Cell: _____

Work: _____

Home: _____

How may we contact you? Please check all that apply

text ☐ email ☐ Home ☐ Cell ☐ work ☐ mail ☐

Occupation: _____

Patient Employer/School _____

How did you hear about us?

_____

Please list your Primary Care Physician:

Name: Dr. _____

_____

Phone #: Fax #: _____

Address or location: _____

Pharmacy Name **Pharmacy Location:** Pharmacy Phone:

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

Vision care plans (such as Superior and EyeMed)

Medical insurance (such as Blue Cross/Blue Shield and Medicare).

Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

*X_____

Patient signature (parent if child) Date

OVER

Patient Insurance Information

Patient Name: _____

Primary Card Holder Information if different from patient:

Name: _____

Date of Birth: _____ Age: _____

Phone Number: _____

Address: _____

_____

Employer: _____

Medical / Primary Insurance Information:

Insurance Carrier _____

Contract/Policy # _____

Group # _____ Copay _____

Secondary/ Vision Insurance Information:

Insurance Carrier _____

Contract/Policy # _____

Group # _____ Copay _____

Insurance authorization and Pharmacy Record Release

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to New Horizons Eyecare / Dr. Anne Garrison Meighen for services provided. I understand that in the event my insurance claim is denied, I will be responsible for any remaining balance. I also give permission for my perscriptions to be requested or pulled from my pharmacy for verification.

_____

Signature Date

Dilation Clause

We include dilation of the pupils as part of our comprehensive exam. This allows a much better view of the interior of the eye in order to detect ocular systemic disease such as retinal detachments, diabetes, and hypertension

_____ Yes, I wish to be dilated. There is no separate fee for this service.

_____ No, I do not wish to be dilated and I understand that the doctor may not be able to detect all eye disease without dilation.

_____ Please Initial

Notice of Privacy Practices

I acknowledge that I been given a copy of New Horizons Eyecare Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____

Contact Lens Agreement

The contact lens evaluation fee includes all follow-up visits for 30 days. Contact lens prescriptions will only be released after the initial evaluation/fitting period is successfully completed (which may include the examination, fitting, evaluation and follow-up visits). After 30 days, if no contact lens follow-up has been performed, office visits fees will be applied.

Patient/Guardian Signature: _____ Date: _____

OVER

What is your current weight? _____

What is your current height? _____

Visual Requirements

Hobbies: _____

type of work: _____

Sports:

Date of Last eye Exam: _____

Dp you wear glasses: YES NO

Do you wear contacts: YES NO

Brand:

Do you sleep in them: YES NO Occasionally

Describe any problems you have had with contacts:

_____

Are you interested in corrective surgery? YES NO

Please let us know why you are coming in to see us today. (List any problems you may be having):

Medications

List all medications you are currently taking including over the counter medicine and eye drops

Name of Drug	Strength	Dosage

Personal Health History

Do you **currently** have any problems in the following areas? Please circle Y or N

CONSTITUTIONAL			**RESPIRATORY**			**INTEGUMENTARY**		
Developmental	Y	N	Cigarette Smoker	Y	N	Eczema	Y	N
Cancer	Y	N	Asthma	Y	N	Rosacea	Y	N
Fatigue Syndrome	Y	N	Bronchitis	Y	N	Psoriasis	Y	N
EARS, NOSE, THROAT			Emphysema	Y	N	Cold Sores	Y	N
Hearing Loss	Y	N	Chronic Obstruction	Y	N	Shingles	Y	N
Sinusitis	Y	N	Sleep Apnea	Y	N	**ENDOCRINE**		
Dry Mouth	Y	N	**GASTROINTESTINAL**			Diabetes Type 2	Y	N
Laryngitis	Y	N	Chrohn's	Y	N	Diabetes Type 1	Y	N
NEUROLOGICAL			Colitis	Y	N	Thyroid	Y	N
Multiple Sclerosis	Y	N	Ulcer	Y	N	Hormone Dysfunction	Y	N
Epilepsy	Y	N	Acid Reflux	Y	N	**HEMATOLOGY/Lymphatic**		
Cerebral Palsy	Y	N	Celiac Disease	Y	N	Anemia	Y	N
Tumor	Y	N	**Genitourinary**			Large volume blood loss	Y	N
Stroke/CVA	Y	N	Kidney disease	Y	N	Ulcer	Y	N
Migraine	Y	N	Prostate Problems	Y	N	Hypercholesteremia	Y	N
Autism Spectrum	Y	N	STD's	Y	N	**Allergy/Immune**		
MENTAL STATUS			Pregnant/Nursing	Y	N	Drug Allergies	Y	N
Depression	Y	N	Herpes	Y	N	Environmental allergies	Y	N
Attention Deficit	Y	N	Chlamydia	Y	N	Rheumatoid Arth	Y	N
Anxiety	Y	N	**Musculoskeletal**			Lupus	Y	N
Bipolar Disorder	Y	N	Arthritis	Y	N	Sjogren Syndrome	Y	N
CARDIOVASCULAR			Osteoarthritis	Y	N			
Hypertension	Y	N	Fibromyalgia	Y	N			
Stroke / CVA	Y	N	Muscular Dystrophy	Y	N			
Heart Disease	Y	N	Ankylosing Spondylitis	Y	N			
Vascular Disease	Y	N	Osteoporosis	Y	N			
Congestive Heart	Y	N	Gout	Y	N			

Allergies

Are you allergic to any drugs or medicines? Yes No
If yes, Please list:

_____

_____

_____

Are you Sensitive to Latex? Yes No

Circle any other allergies:

Biotrue Pollen Bee Stings
Animal dander Dust Hayfever
Ragweed Dairy Nuts
Shellfish Dyes

Other (please list): _____

Social History

All information listed below is strictly confidential. You may choose to discuss this with the doctor.

Do you drive? Y N If yes do you have visual difficulty when driving? Y N If yes,please describe:

Smoking Status - Current smoker Y N Have you ever smoked? Y N

If you smoke what is your smoking preference? Cigarettes Cigars Pipe Smokeless tobacco

How much / how often? _____

Do you drink alcohol? Y N if yes how often _____

Do you use illegal drugs? Y N if yes how often _____

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

Family Health History

Medical	Please circle relationship if anyone in your family has the following:					
Thyroid	Mother	Father	Brother	Sister	Son	Daughter
Lupus	Mother	Father	Brother	Sister	Son	Daughter
Diabetes	Mother	Father	Brother	Sister	Son	Daughter
Heart Disease	Mother	Father	Brother	Sister	Son	Daughter
Hypertenson	Mother	Father	Brother	Sister	Son	Daughter
Lung Disease	Mother	Father	Brother	Sister	Son	Daughter
Stroke	Mother	Father	Brother	Sister	Son	Daughter
Cancer	Mother	Father	Brother	Sister	Son	Daughter

Ocular History

Glaucoma	Mother	Father	Brother	Sister	Son	Daughter
Lazy eye	Mother	Father	Brother	Sister	Son	Daughter
Macular Degeneration	Mother	Father	Brother	Sister	Son	Daughter
Cataracts	Mother	Father	Brother	Sister	Son	Daughter
Eye Turns	Mother	Father	Brother	Sister	Son	Daughter
color Blindness	Mother	Father	Brother	Sister	Son	Daughter

HIPAA RELEASE

Who may we give information to on your behalf? List any family or friends that we may talk to :
***(Parents: Please list your name as well as any other family members that we may talk to)

Name: _____ Relationship_____ Phone #:_____

Name: _____ Relationship_____ Phone #:_____

Name: _____ Relationship_____ Phone #:_____

Name: _____ Relationship_____ Phone #:_____

Patient/Guardian Signature: _____ Date: _____