Everything in SIGHT OPTOMETRY

NEW PATIENT FORM

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

PATIENT INFORMATION

Last Name, First Name		Street Address	
Date of Birth		Suite/Apt.	
Daytime Phone		City	
Mobile Phone		State	
Email		Zip code	

GUARDIAN INFORMATION (If patient is under 18 years of age)

Last Name, First Name		Street Address	
Date of Birth		Suite/Apt.	
Daytime Phone		City	
Mobile Phone		State	
Email		Zip code	

VISION INSURANCE INFORMATION

Insured Name		Last Four of Social	
Insured Date of Birth		Policy/I.D. No.	
Provider Name		Group No.	

HOW DID YOU HEAR ABOUT *Everything In Sight*?

Doctor Referral	Website
Friend/Family Referral	Social Media
Referral Name _____	Google

FINANCIAL ASSIGNMENT AGREEMENT

☐ I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

ACKNOWLEDGMENT OF HIPPA

☐ Yes, I have read or had explained to me by this office HIPPA practices and I wish to continue my care under said terms

☐ No, I have not read the this office's HIPPA but was given the opportunity and declined. I wish to continue my care under said terms

☐ The HIPPA could not be read due to the emergent nature of the care needed

Patient Signature/Guardian_____ Date_____

GENERAL MEDICAL HISTORY

Primary Care Physician's Name _____ Primary Care Physician's Phone_____

When was your last eye exam? _____ Medications _____

Please list any surgeries: _____

Do you have any of the following conditions?

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Migraines/headaches
- ☐ Multiple sclerosis
- ☐ Hypertension
- ☐ Other: _____

Do you have any family history of the following?

- ☐ Blindness
- ☐ Diabetes
- ☐ Eye Turn/Lazy Eye
- ☐ Glaucoma
- ☐ Hypertension
- ☐ Macular Degenertaion

Please list any allergies: _____

VISION HISTORY

Please check all that apply:

- ☐ Amblyopia (lazy eye}
- ☐ Blurred vision at a distance
- ☐ Blurred vision at near
- ☐ Burning
- ☐ Double vision
- ☐ Drooping eyelid(s}
- ☐ Dryness
- ☐ Eye pain and/or soreness
- ☐ Floaters or spots
- ☐ Fluctuating vision
- ☐ Foreign body sensation
- ☐ Halos
- ☐ Infection of eye or lid
- ☐ Itching
- ☐ Loss of peripheral vision
- ☐ Loss of vision
- ☐ Mucous discharge
- ☐ Stopped wearing contacts
- ☐ Stopped wearing glasses
- ☐ Redness
- ☐ Regular headaches
- ☐ Sandy or gritty feeling
- ☐ Sensitivity to light/glare
- ☐ Strabismus (crossed eye}
- ☐ Tired eyes
- ☐ Watery eyes

GLASSES HISTORY

What glasses do you own?

- ☐ Backup pair
- ☐ Bifocals
- ☐ Trifocals
- ☐ Distance
- ☐ Progressive lenses
- ☐ Reading
- ☐ Safety Glasses
- ☐ Single Vision
- ☐ Sports Glasses
- ☐ Sunglasses

Check any that apply:

- ☐ Allergic to nickel
- ☐ I do not want to wear glasses
- ☐ Incorrect prescription
- ☐ Need spare glasses
- ☐ Need sunglasses with UV
- ☐ Problems with current glasses
- ☐ Problems with glare
- ☐ Problems with night vision
- ☐ Other: _____

How many hours per day do you spend using a computer?_____

CONTACT LENS HISTORY (check all that apply)

What brand of contacts do you wear? _____ How often do you replace them? _____

How old are your current contacts? _____ What solution do you use for soaking? _____

What is your typical wearing schedule?_____

Check any that apply:

- ☐ I do not want to wear contacts
- ☐ Incorrect prescription
- ☐ Interested in non-surgical correction
- ☐ Other: _____
- ☐ Interested in refractive laser surgery
- ☐ Need spare contacts
- ☐ Problems with current contacts