NEW PATIENT INFORMATION/UPDATE FORM

Patient's Name	
Patient's Date of Birth	
Patient's Address	______________________ City: State: Zip:
Patient's Phone Number And Email	Best Daytime #: ______________________ Other phone #: ______________________ May we text you if cell phone: YES ☐ NO ☐ Email: ______________________ May we send you reminders: YES ☐ NO ☐
Sex	Male ☐ Female ☐
Marital Status	Single ☐ Married ☐ Other ☐
Were you referred to us?	YES ☐ NO ☐ By Who: ______________________
Last Eye and Medical Exams	Date of Last Eye Exam: __________ Date of Last Medical Exam: __________ Name/Info of Last Eye Doctor: __________ Name/Info of Last Primary Care Physician: __________

INSURANCE INFORMATION

Vision Plan ______________________

Insured's Name______________________

Insured's DOB ______________________

Insured's ID#______________________

Relationship to Member ______________________

Medical Plan ______________________

Insured's Name______________________

Insured's DOB______________________

Insured's ID #______________________

Relationship to Member ______________________

I, the undersigned, understand that I am financially responsible for all fees in which services were rendered.

If using a "vision plan", I understand that it does not cover 'medical' treatment of the eyes, and that it only covers basic vision related exams and/or materials related to glasses once during a specific benefits period. For "medical" or red eye treatments/visits, Lake Forest Family Optometric Eyecare can bill for the visit using the patient's 'medical' insurance plan.

I understand that if during a "vision" exam, a "medical" eye problem is detected, my "medical" insurance may be billed for all future medical office visits related to diagnosis and treatment of the medical eye problem. I understand that occasionally "medical" eye treatments may take place on the same day as my "vision" exam, in which case two separate claims may be submitted (a "vision" plan services and a "medical" insurance claim). To this end, I also understand that I may be charged co-payments for "vision" services, in addition to "medical" co-payment services.

I authorize Lake Forest Family Optometric Eyecare to bill my medical insurance for medical services and my vision plan for vision services and I directly assign to Lake Forest Family Optometric Eyecare all benefits payable to both medical plans and vision plans for services rendered.

I acknowledge that I have read the "Notice of Privacy Practices" located at the front desk and understand that per Federal law (HIPAA) my personal information is kept confidential. I understand, per HIPAA regulations that Lake Forest Family Optometric Eyecare may share my information with insurance companies in order to authorize services, secure payment, or for audit purposes.

I authorize the use of this signature on all future insurance claims:

Signature of Patient or Responsible Party:______________________ Date:__________

Patient Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular degeneration		
Retinal disease		
Retinal detachment		
Loss of vision/Blindness		
Eye turn/Strabismus		
Amblyopia/Lazy eye		
Dry eye		
Eye allergies		
Arthritis		
Autoimmune Dz		
Hypertension		
Diabetes		
Hypercholesterolemia		
Cardiovascular disease		
Stroke		
Thyroid		
Cancer		
Do you wear glasses/contact lenses?		
Have you had any surgery?		

What type of eye surgery? Systemic surgery?

Other eye disease you have not listed?

Social History	Yes	No
Do you smoke?		
If yes, how many pack(s) per day?		
How many years have you smoked?		
Quit smoking?		
Do you drink alcohol?		
Social use?		
Above average use?		
Do you use narcotics?		
Recreational?		
Chemical dependence?		
Computer use >4 hours per day		
Tablet/smart phone use >4 hours/day		

Activities you would like us to know that may affect your vision?

Family Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular degeneration		
Blindness		
Retinal disease		
Eye turn		
Amblyopia/Lazy eye		
Dry eye		
Hypertension		
Diabetes		
Thyroid		
Arthritis		

Other diseases (i.e. Cancer) that your family members have? (List below)

Are you taking any medications? ☐ Yes ☐ No

List all current medications:

____

____

____

____

(Attach list) Yes☐ No☐

List medications you are allergic to:

____

____

____

____

No known drug allergies ☐

Are you pregnant? Yes☐ No☐

Are you nursing? Yes☐ No☐

(If pregnant or nursing we may postpone dilation test. If dilation test is performed, be advised that near vision may be affected. Please be careful when driving home).

Would you like to take a retinal photo? Yes☐ No☐ (Co-pays may apply)

Please initial here:_______ acknowledging all things discussed on this page.