NEW PATIENT FORM

PATIENT INFORMATION

FIRST LAST If a minor, name of parent or guardian

NICKNAME/PREFERRED NAME OCCUPATION

ADDRESS CITY STATE ZIP

PREFERRED PHONE NUMBER SECONDARY PHONE NUMBER

BIRTHDATE SS# EMAIL

EMERGENCY CONTACT PHONE NUMBER

INSURANCE INFORMATION

INSURANCE COMPANY

MEMBER NAME MEMBER ID MEMBER EMPLOYER

MEMBER BIRTHDATE MEMBER SS RELATIONSHIP TO MEMBER

HOW DID YOU HEAR ABOUT DISTINCTIVE EYEWEAR?

IF YOU ARE A MINOR (UNDER 18), PLEASE FILL OUT THE FOLLOWING.

PERSON FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT

ADDRESS CITY STATE ZIP PHONE NUMBER

NEW PATIENT FORM

TELL US ABOUT YOUR EYES

Currently wear glasses Y/N

Currently wear contacts Y/N Type and Brand _____

Date of last eye exam _____

Reason for today's visit _____

Have you ever had:
Eye Surgery Y/N Eye Infections Y/N Eye Injury Y/N Headaches Y/N

Do YOU have any history of:
Diabetes Y/N High Blood Pressure Y/N High Cholesterol Y/N

Other _____

Is there a FAMILY history of:
Glaucoma Y/N Macular Degeneration Y/N Diabetes Y/N

Cataracts Y/N Retinal Detachment Y/N High Blood Pressure Y/N

Currently taking any medication? Y/N (list)_____

Medication allergies? Y/N (list)_____

I authorize the release of any medical or other information necessary to process claims arising from services provided. I assume all financial responsibility for this account and all amounts due regardless of insurance coverage. I have read and understand my rights under federal HIPAA laws.

Signature_____ **Date**_____

Relationship_____
(if signing for a minor)