New Patient Form

Patient Information

Welcome to Modern Eyes Optometry. We are delighted to have you as a patient and we appreciate you choosing us for your eye care needs. Please take a few moments to complete the following information.

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Male ☐ Female

First Name _____ M.I. _____ Last Name _____ Date of Birth _____

Street Address, Apt _____ City, State, Zip _____

Home Phone _____ Cell or Work Phone (Please Circle) _____ Email Address _____

Employer / Occupation _____

Would you like to receive an email to sign up for our newsletter, reminders and other promotions? ☐ Yes ☐ No

Person Responsible for Account (if patient is a minor) _____ Social Security Number (of person responsible) _____

How did you find us? (Please check all that apply)

☐ Phone Book ☐ Internet ☐ Post Card ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Walk-By ☐ Other ☐ Doctor (Please Name) _____

Primary Health Insurance Information

Name of Insurance Company _____ Identification Number _____

Primary Insured's / Sponsor's Name _____ Primary Insured's Date of Birth _____

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

Secondary Health Insurance Information

Name of Insurance Company _____ Identification Number _____

Primary Insured's / Sponsor's Name _____ Primary Insured's Date of Birth _____

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

Vision Insurance Information

Name of Insurance Company _____ Identification Number _____

Primary Insured's Name _____ Primary Insured's Date of Birth _____

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

Please Read:

Please be advised that the patient is responsible for providing a current copy of his/her insurance cards and Photo ID. Your Photo ID is important to protect against medical identity theft. The patient is also responsible for obtaining and providing a referral when required by the insurance company. Without the required information it will be the responsibility of the patient to pay for the services rendered on the day of the visit. Please be aware that Medicare and many other health insurance companies will not cover charges for items which may include, but are not limited to, refractions or medical supplies, which may be part of your eye examination. Healthcare regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud. Non-covered service fees and co-payments are DUE ON THE DAY THE SERVICES ARE RENDERED.

OTHER SIDE →

Patient History

Primary Care Physician and Clinic Name _____

Primary Care Physician Phone Number _____

Last Health Exam _____

Last Eye Exam _____

Current Medications (including eye drops):	Past Surgeries: (General and/or Eye Surgery, including LASIK)	Specific Allergies & Allergies to Medicines:

Do you have or are currently experiencing any of the following? Check all the apply

Eye History

Glaucoma ☐
Cataracts ☐
Macular Degeneration ☐
Prior Retinal Detachment ☐
Color Blindness ☐
Glare / Light Sensitivity ☐
Floating Spots ☐
Flashing Lights ☐
Burning, Itching, or Tearing ☐
Sandy or Gritty Feeling ☐
Redness ☐
Eye Pain or Soreness ☐
Previous Eye Injury ☐
Previous Eye Surgery ☐
Double Vision ☐
Strabismus (Crossed Eyes) ☐
Other (List Below) ☐
_____

General Health Conditions

Fever ☐
Weight loss ☐
Currently Pregnant ☐
Thyroid Problems ☐
Diabetes ☐
Deafness ☐
Sinusitis ☐
Osteoarthritis ☐
Rheumatoid Arthritis ☐
Osteoporosis ☐
Previous Stroke ☐
Seizures ☐
Headaches ☐
High Blood Pressure ☐
Chest Pain ☐
Heart valve disease ☐
Previous heart attack ☐
High cholesterol ☐
Anemia ☐
Cancer ☐
Asthma ☐
Chronic bronchitis ☐
Wheezing ☐
Shortness of breath ☐
Kidney stones ☐
Autoimmune disease ☐
HIV / AIDS ☐
Depression ☐
Panic attacks ☐
Anxiety ☐
_____ Other ☐

Family History

Diabetes ☐
High Blood Pressure ☐
Heart Disease ☐
Cancer ☐
Cataracts ☐
Glaucoma ☐
Macular Degeneration ☐

PLEASE READ: DILATION CONSENT

DILATION of your eyes is part of a comprehensive eye examination.

To dilate the eyes, drops are used to relax the muscle which controls the pupil size, allowing the pupil to fully open. A wait time of 20 minutes is required to allow the drops to take effect before the doctor can complete the dilation.

Side effects of dilation can include short-term blurred vision up close, and in some cases far away, as well as sensitivity to light. (Temporary sunglasses will be given to the patient to help with this side-effect.)

Patients with high prescriptions, new floaters and flashes, diabetes, and high blood pressure are STRONGLY advised to have their eyes dilated yearly. In addition, patients with a family history of glaucoma, macular degeneration or blindness should follow the same guidelines.

REFUSAL TO HAVE YOUR PUPILS DILATED MAY CAUSE YOUR DOCTOR TO BE UNABLE TO DETECT CERTAIN DISEASES.

Please check one of the following:

- ☐ I AGREE to have my eyes dilated (or give permission to have my child's eyes dilated, if the patient is a minor).
- ☐ I understand the importance of dilation but REFUSE to dilate my eyes today.
- ☐ I would like to DISCUSS dilation with the doctor.

By signing below, you are attesting that all information you have presented here is correct, accurate, and up to date.

Signature of Patient OR Guardian (if patient is a minor) _____

Date _____