NEW PATIENT INFORMATION

Date:_____ Check-in by:_____

Preferred Language: ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ others _____

Last Name_____ First Name_____ M / F Birth Date _____

If patient is under 18 years old: Mother _____ Father _____

In custody of: ☐ both parents ☐ Mother ☐ Father ☐ Guardian / Relation_____

Address: _____City_____State_____Zip code_____

Cell Phone:_____ Secondary Tel: home / work / cell _____

Email_____ Occupation/Grade Level & Employer/School_____

Referred By: ☐ walk by ☐ insurance listing ☐ family ☐ friend ☐ family doctor ☐ other _____

Emergency contact: Name _____ Relationship _____ Phone # _____

Previous Patient? Y / N : Date of Last Eye Exam _____ From Dr. _____

History of Glasses Wear: ☐ Never ☐ Age of present glasses _____

History of Contacts Wear: ☐ Never ☐ Last worn contacts _____

Reason for Today's Visit:
☐ Eye problem(s): such as red eyes, itchy eyes, watery eyes, eye pain, seeing spots etc.
☐ Vision Problem(s): Need/want new/update glasses and/or contact lenses
☐ No problem: Eye wellness check
☐ Other _____

Are you planning to get new glasses today? ☐ yes ☐no ☐undecided New contacts today? ☐ yes ☐ no ☐ undecided

Do you or any of family members (Grandparents, parents, brothers or sisters) have any of these conditions?

	Self	Family	None		Self	Family	None		Yes	No
Diabetes	☐	☐	☐	Retinal Disease	☐	☐	☐	Do you see double?	☐	☐
High Blood Pressure	☐	☐	☐	Glaucoma	☐	☐	☐	Frequent headaches?	☐	☐
High Cholesterol	☐	☐	☐	Cataracts	☐	☐	☐	Are you pregnant?	☐	☐
Heart Disease	☐	☐	☐	Eye Surgery	☐	☐	☐	Are you breastfeeding?	☐	☐
Asthma	☐	☐	☐	Eye Injury	☐	☐	☐	Eyes Been dilated	☐	☐
Other	☐	☐	☐	Other	☐	☐	☐	Primary Care Dr. _____		

Additional Comments: _____

_____

List of current eye drops (prescription or over the counter): ☐ None ☐ List _____

List of current all other medications (prescription or over the counter): ☐ None ☐ List _____

_____

Known food or medication allergies: ☐ None ☐ List:_____

List any person or entity (spouse, parents, children, or doctor office) that you approve to receive your protected health information and financial information without any further authorization. (let us know if you want more than 2 people)

1) Name _____ Relation _____ 2) Name _____ Relation _____

By signing below, I acknowledge that

1) I voluntarily consent to any and all eye care treatment and diagnostic procedures by **ENVUE OPTOMETRY** and its associated doctors and other personnel.

2) I have read, understand, and/or received a copy of the HIPAA disclosure (Notice of Privacy Practice) and Office Policies.

3) I understand that eligibility and benefit provided by the insurance / vision plan are not a guarantee of payment. I authorize **ENVUE OPTOMETRY** to release any information to process all insurance claims for services rendered. I also authorized payment of benefits directly to this office. I understand that I am responsible for any charge not paid by my insurance / vision plan as well as any deductible and / or co-pays.

Patient / Guardian Signature_____ Date _____

Print Name of the Signer for Minor_____ Relation _____

For Office Use Only: Last WVE:

Health Insurance (PPO / HMO): ▫ Anthem ▫ Blue Cross ▫ Blue Shield ▫ Health Net ▫ Kaiser ▫ United Health Care ▫ other _____

Vision Plan: ▫ Self Pay ▫ VSP: sig - choice - value – essen; 2nd pair: CVC; safety; PEC - DEPP ▫ EyeMed ▫ MCal: reg - VSP - March - Envolve ▫ Davis ▫ Spectera ▫ other _____

Insured Name_____ Relationship to patient: ▫ self ▫ spouse ▫ parent ▫ other_____

DOB_____ Last 4 SS#_____ ID # _____