METROEYECARE

New Patient Welcome Form

Welcome and thank you for choosing us for your eyecare needs. Please complete this form and ask us for assistance if needed. All information will remain confidential.

PATIENT DEMOGRAPHICS

DATE: ____________

FIRST NAME ______ MIDDLE NAME ______ LAST NAME ______ NICKNAME ______ PRONOUNS ______

DOB:____________________ ☐ Male ☐ Female ☐ Trans ☐ Non-binary ☐ Other ☐ Decline to answer

ADDRESS ______ CITY ______ STATE ______ ZIP ______

PHONE NUMBER: ____________________ PREFERRED COMMUNICATION: ☐ Phone ☐ Text

EMAIL ADDRESS: ____________________ ☐ Email ☐ US Mail

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other ________________

RACE: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian ☐ Self-describe: ________________ ☐ Decline

ETHNICITY: ☐ Hispanic or Latino/a/x ☐ Not Hispanic or Latino/a/x ☐ Decline

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

EMPLOYER/SCHOOL:________________________ OCCUPATION: ________________________ ☐ Full-time ☐ Part-time

Minors Only

Parent/Guardian: ____________ Address: ____________

Phone #: ____________ Work phone #: ____________ Employer:

Parent/Guardian: ____________ Address: ____________

Phone #: Work phone #: Employer:

MEDICAL HISTORY

What is the main reason for your visit today? ____

____

Date of last eye exam/office: ____________

Date of last medical exam: ____________

Primary care physician/office: ____________

Do you wear glasses?: ☐ yes, ___ years old ☐ no

Do you wear contact lenses?: ☐ yes, ___ hrs/day ☐ no

Contact lens type/brand: ____________

If yes, do you wear them for: ☐ distance ☐ near ☐ both

(Females) Are you pregnant?: ☐ yes ☐ no

Allergies to medications: ____________ ☐ no known drug allergies

Other allergies: ____________

List all current medications, vitamins, supplements, & eye drops:

Social History:

Alcohol use: ☐ yes ☐ no

Tobacco use: ☐ yes ☐ no

Recreational drug use: ☐ yes ☐ no

Check all current symptoms:

- ☐ **NONE**
- ☐ Blurred vision
- ☐ Eye injury
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Burning eyes
- ☐ Itching eyes
- ☐ Tearing/watering eyes
- ☐ Discharge from eye
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Frequent headaches
- ☐ Poor night vision
- ☐ Bothersome night glare
- ☐ Double vision
- ☐ Total loss of vision
- ☐ Floaters in vision
- ☐ Flashes of lights in vision
- ☐ Other ________________

Do you have any of the following conditions:

- ☐ **NONE**
- ☐ Diabetes
  - Type I or Type 2
  - Year diagnosed: ________
  - Last A1c %: ____ date: ______
  - Blood sugar ranges: _________
- ☐ High blood pressure
- ☐ Heart disease or stroke
- ☐ High cholesterol
- ☐ Chronic allergies
- ☐ Lung disease
- ☐ Asthma/COPD
- ☐ Thyroid dysfunction
- ☐ Arthritis
- ☐ Colitis
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Cancer ________________
- ☐ Other ________________

Have you ever been diagnosed with any of the following:

- ☐ **NONE**
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Diabetic retinopathy
- ☐ Chronic dry eyes
- ☐ Chronic red eyes/uveitis
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (lazy eye)
- ☐ Keratoconus
- ☐ Retinal detachment
- ☐ Other ________________

Have you ever had surgery for:

- ☐ **NONE**
- ☐ Cataract
- ☐ Retinal detachment
- ☐ Eye muscle surgery
- ☐ Eye injury
- ☐ LASIK/PRK date: _________
- ☐ Foreign body removal
- ☐ Corneal transplant
- ☐ Other eye surgeries
- ☐ Other major surgeries:

____
____
____

Has anyone in your family had:

	Relationship
☐ **NONE**	
☐ Cancer	________
☐ Diabetes	________
☐ High blood pressure	________
☐ Macular degeneration	________
☐ Glaucoma	________
☐ Blindness	________

PATIENT NAME: ____ DATE: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare.

____ ______________________________

Signature of Patient/Parent/Legal Guardian/or Representative Relationship to patient

NON-COVERED SERVICES

I understand that I am responsible for fees not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

AUTHORIZATION TO RELEASE INFORMATION

I authorize my insurance company to release information regarding my coverage to Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare. I authorize agents of any hospital, or previous doctors to furnish Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare copies of any records of my medical history, services or treatments. I authorize the release of any medical information and/or reports related to my treatment to any doctor, optical supplier, pharmacy, or insurance company as needed or requested by me. I agree to a review of my records for purposes of internal audits, research, and quality assurance review within Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare.

ASSIGNMENT OF BENEFITS

My right to payment for all procedures, test, supplies, and technical/physician services including major medical benefits are hereby assigned to Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare. This assignment covers any and all benefits under/over Medicare, other government sponsored programs, private insurance and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance company does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to Altoona EyeCare/ EyeCare Associates of Ankeny/ Johnston EyeCare.

I have read the above statements and accept the terms. I understand that I may revoke this consent, in writing, at any time.

____ ______________________________

Signature of Patient/Parent/Legal Guardian/or Representative Relationship to patient

Contact Lens Prescription Acknowledgement

I acknowledge that I will be provided with a copy of my contact lens prescription at the completion of my contact lens fitting.

____

Signature of Patient/Parent/Legal Guardian/or Representative

Place a check mark in the box below next to the person or persons designated as your EMERGENCY CONTACT
The following individuals have my authorization to access my Protected Health Information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Name	☐	Relationship	Phone
________________________	☐	________________________	________________________
Name		Relationship	Phone
________________________	☐	________________________	________________________
Name		Relationship	Phone