

# New Patient Information Form

Patient's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Marital Status (circle one): Married   Single   Divorced   Legally Separated   Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

## Insurance Policy Holder Information

Policy Holder's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

### INSURANCE INFORMATION

\_\_\_\_\_  
Name of Vision Insurance

\_\_\_\_\_  
Name of Medical Insurance

\_\_\_\_\_  
Policy / Identification #

\_\_\_\_\_  
Policy / Identification #

\_\_\_\_\_  
Group #

\_\_\_\_\_  
Group #

**We ask all patients to show their insurance cards, so that we may scan them into our system.**

#### FINANCIAL DISCLAIMER

I authorize the release of any medical information necessary to provide the most beneficial and complete eye health examination. I acknowledge that Wyntre Brooke Eye Associates, Inc. will attempt to verify plan eligibility for services and/or materials prior to the exam. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. I understand it is my responsibility to check with the plan administrator if I have any questions regarding my eligibility. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand the Exam Co-Payment is due at the time services are rendered. When materials are ordered (glasses or contact) a 50% deposit must be paid with the remaining balance due when materials are received. I understand that if there is an unpaid balance beyond 30 days, interest will accrue. My account may be turned over to collections and I am responsible for all collections fees that will be added.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# New Patient Medical History Form

Patient's Full Name: \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_

Do you currently see an ophthalmologist, endocrinologist or rheumatologist? If so, please list their name(s).

\_\_\_\_\_

<b>MEDICATIONS</b>
Do you have any allergies to medications? If yes, please list:
List any medications you are currently taking (including oral contraceptives, aspirin, over the counter medications and vitamins):
List any ocular medications you are currently taking (including oral medications, eye drops and eye ointments):

**MEDICAL HISTORY: Do you currently, or have you ever had any problems in the following areas?**

		Y	N	List Condition		Y	N	List Condition
<b>CARDIOVASCULAR</b>	Heart Condition				<b>IMMUNOLOGIC</b>			Lyme Disease
	High Blood Pressure							Sarcoidosis
	Cardiovascular Disease							HIV/AIDS
	Stroke							
<b>CONSTITUTIONAL</b>	Fever				<b>INTEGUMENTARY</b>			Skin
	Weight Loss or Gain							Lupus
								Rosacea
<b>ENDOCRINE</b>	Diabetes				<b>MUSCULOSKELETAL</b>			Rheumatoid Arthritis
	Thyroid Condition							Muscle Pain
	Crohn's Disease							Joint Pain
	Gout							Down's Syndrome
<b>GASTROINTESTINAL</b>	Hepatitis				<b>NEUROLOGICAL</b>			Headaches/Migraines
	Acid Reflux							Brain Condition
	Colitis							Vertigo
<b>GENITOURINARY</b>	Kidney Disorder				<b>PSYCHIATRIC</b>			Depression
	Bladder Disorder							Autism
	Prostate Disorder				<b>RESPIRATORY</b>			Asthma
	Ovarian Disorder							Chronic Bronchitis
<b>HEAD</b>	STDs						Emphysema	
	Sinusitis						Lung Cancer	
	Hearing Loss				<b>ALLERGY</b>			Seasonal
	Meniere's Syndrome							Environmental
<b>HEMATOLOGIC/ LYMPHATIC</b>	Anemia							
	Breast Cancer							
	Sickle Cell Disorder							

Are you pregnant? \_\_\_\_\_ If so, how many weeks? \_\_\_\_\_

## New Patient Medical History Form

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OCULAR HISTORY	Y	N	HOW LONG?
Cataracts			
Dry Eye			
Eye Infections			
Eye Turn			
Glaucoma			
Macular Degeneration			
Retinal Disease			
Other:			

**FAMILY HISTORY – Any family history of the following?**

SYSTEMIC HISTORY	Y	N	RELATIONSHIP	OCULAR HISTORY	Y	N	RELATIONSHIP
Arthritis				Blindness			
Cancer				Cataract			
Diabetes				Eye Turn			
Heart Disease				Glaucoma			
High Blood Pressure				Macular Degeneration			
Kidney Disease				Retinal Detachment/Disease			
Lupus							
Thyroid Disease							

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date