NEW PATIENT INFORMATION FORM

DATE:_____

(PLEASE PRINT CLEARLY)

PATIENT NAME: MR/MRS/MISS/MS _____ DATE OF BIRTH _____AGE _____

ADDRESS: _____ E-mail _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____CELL: ( )_____

OCCUPATION/ STUDENT: _____ SOCIAL SECURITY #: _____

PLACE OF EMPLOYMENT / SCHOOL: _____ GRADE: _____

PARENTS NAME: (IF PATIENT IS A MINOR) _____

PRIMARY CARE PHYSICIAN: _____

REASON FOR EXAMINATION?

_____ EYE EXAM _____ BLURRED DISTANCE/ NEAR

_____ CONTACT LENS EXAM _____ DOUBLE VISION

_____ LASIK CONSULTATION _____ EYES TURN IN OR OUT

_____ EYESTRAIN _____ HEADACHES

OTHER_____

DATE OF LAST EYE EXAM: _____ EXAMINING DOCTOR _____

OCULAR HISTORY: (PLEASE CIRCLE)

HAVE YOU EVER HAD AN EYE INFECTION, INJURY OR SURGERY? ……YES / NO

IF YES WHAT TYPE? _____

FAMILY OCULAR HISTORY: ANY MEMBER HAD ONE OR MORE OF THE FOLLOWING?

GLAUCOMA…… YES / NO IF YES, RELATIONSHIP TO YOU: _____

AMBLYOPIA …….. YES / NO IF YES, RELATIONSHIP TO YOU: _____

CATARACTS ……. YES / NO IF YES, RELATIONSHIP TO YOU: _____

OTHER EYE DISEASE: _____ RELATIONSHIP TO YOU: _____

DO YOU HAVE FREQUENT HEADACHES? …… YES / NO

IF YES, WHERE: _____ WHEN: _____ HOW OFTEN: _____

DO YOU EVER SEE DOUBLE? …….. YES / NO

IF YES, WHEN? _____

DO YOU WORK AT A COMPUTER TERMINAL? …….. YES / NO

DO YOU HAVE COLOR VISION PROBLEMS? …….. YES / NO

(CONTINUED ON BACK)

CONTACT LENS HISTORY: (PLEASE CIRCLE)

HAVE YOU WORN CONTACTS IN THE PAST? …… YES / NO
DO YOU PRESENTLY WEAR CONTACTS? …….. YES / NO

HOW OLD ARE YOUR CONTACTS? _____ HOURS PER DAY WORN? _____

CIRCLE TYPE OF LENS WORN PLEASE CIRCLE ALL THAT APPLY:
GAS PERMEABLE / SOFT DAILY WEAR / EXTENDED WEAR DISPOSABLE / TORIC / BIFOCAL

DISINFECTANT METHOD: OPTIFREE / RENU / COMPLETE / PEROXIDE SYSTEM / BOSTON / OTHER

MEDICAL HISTORY: (PLEASE CIRCLE)

DO YOU HAVE: / HYPERTENSION / DIABETES / THYROID CONDITION / ARTHRITIS/ HEART PROBLEMS?
OTHER MEDICAL PROBLEMS:

_____

PLEASE LIST CURRENT MEDICATIONS:

_____

DO YOU HAVE ANY DRUG ALLERGIES OR SENSITIVITIES? …… YES / NO
IF YES, PLEASE LIST: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____Employer:_____

IDENTIFICATION NUMBER: _____Group # _____

NAME OF INSURED: _____DATE OF BIRTH:_____

***Authorization to release information: I authorize benefits payable for this claim to be paid directly to the provider, Hauser Vision Care, otherwise, payable to me. I acknowledge that this claim is not for the treatment of any occupational accident or third party injury and I hereby authorize any of the undersigned to disclose any necessary information related to the processing of this claim. Verifying insurance and eligibility does not guarantee payment of services.**

Signature:_____Date:_____

PAYMENT IS DUE AT THE TIME OF SERVICE.

PAYMENT CAN BE; CASH, CHECK, VISA/MASTERCARD/DISCOVER/DEBIT

HOW DID YOU HEAR OF US?
_____ PATIENT REFERRAL_____ FAMILY FRIEND REFERRAL
_____ ADVERTISING
_____ PHONE BOOK _____ DIRECT MAIL_____NEWSPAPER
_____ INSURANCE PROVIDER _____EMPLOYER
_____ LOCATION_____ INTERNET/WEB SITE

HOW MANY HOURS ON A COMPUTER PER DAY:_____

DO YOU PARTICIPATE IN SPORTS OR ANY SPECIAL INTERESTS? _____

HIPPA Privacy Policy

HVC complies with protection of your health records. Would you like a copy of our privacy policy? **Yes** **No**