THIRD AVENUE EYECARE

Name:_____ M / F Home:_____

Address:_____ Cell:_____

City, State, Zip_____ Work Phone:_____

Social Security#: _____ Birth Date:_____ Age:_____ Spouse's Name:_____

Occupation:_____ Employer:_____

Email Address:_____ can we contact you via email? Y / N

Race: (circle) American Indian Asian Black/African American Caucasian Hispanic Pacific Islander Other Decline

Medical Dr.:_____ Phone:_____ Last Visit:_____

Previous Eye Dr.:_____ Phone:_____ Last Visit:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

How were you referred to our office:_____

Do you wear **glasses: NO / YES** how long _____ ***and*** full-time / part-time ***for*** near / far / both

Do you wear **contact lenses**: **NO / YES** how long _____ soft / gas perm / specialty _____

Reason for visit today:_____

Have you had any **EYE** surgeries? **NO / YES** If ***yes***, what, which eye, when:

_____

Have you had any other surgeries? **NO / YES** If ***yes*** what and when:

_____

PATIENT **EYE** HEALTH HISTORY

	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (muscle surgery)	☐	☐
Age Related Macular Degen.	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataracts Removed?	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinal Hole or Tear	☐	☐
Dry Eye Syndrome	☐	☐
Floaters	☐	☐
OTHER?	☐	☐

Please List _____

FAMILY **HEALTH** and **EYE** HEALTH HISTORY

	YES	NO	**RELATIONSHIP**
Glaucoma	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other Retinal Disorder	☐	☐	_____
Strabismus (muscle surgery)	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid Disorder	☐	☐	_____
High Cholesterol	☐	☐	_____
Hypertension	☐	☐	_____

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this portion directly with your doctor if you prefer.

Do you drive? NO / YES If yes, do you have visual difficulty when driving? NO / YES Explain: _____

CIRCLE THE FOLLOWING that apply to you:

1. **SMOKING**: CURRENT everyday/someday / FORMER SMOKER year quit: _____ / NEVER SMOKER
2. **DRINKING**: NON / TRIVIAL (less than 1 a day) / LIGHT (1-2 a day) / MODERATE (3-6 a day) / HEAVY (6+ a day)
3. **DRUGS**: NEVER / MARIJUANA (medical or recreational) / ILLEGAL DRUGS what/when: _____

Do you take any **medications** or **supplements**? **NO / YES** if ***yes*** please list:

_____

_____

Are you allergic to any medications? **NO / YES** If ***yes*** please list:

Do you have any **CURRENT EYE** issues: **NO / YES** If ***yes*** please explain :

_____

REVIEW OF SYSTEMS

Do **you** currently, or have you ever had any problems in the following area:

SYSTEM	NO	YES	?
VASCULAR/CARDIOVASCULAR			
High Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Stroke	☐	☐	☐
EARS, NOSE, THROAT, MOUTH			
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
GASTROINTESTINAL			
Crohns Disease	☐	☐	☐
Hepatitis A B C	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
If **YES** what:_____			
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Arthritis	☐	☐	☐
MS	☐	☐	☐
Fibromyalgia	☐	☐	☐
INTEGUMENTARY			
Basal Cell Carcinoma*	☐	☐	☐
*WHERE ON BODY: _____ WHEN:_____			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Sjogrens	☐	☐	☐
CANCER*	☐	☐	☐
*WHERE ON BODY:_____WHEN:_____			
HOW TREATED: _____			
PSYCHIATRIC			
Depression	☐	☐	☐
Dementia	☐	☐	☐
Bi-Polar Disorder	☐	☐	☐

SYSTEM	NO	YES	?
NEUROLOGICAL			
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Head Trauma	☐	☐	☐
If yes, what: _____			
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
☐Hypothyroid ☐Hyperthyroid			
Diabetes Type circle 1 or 2	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
Allergy Shots	☐	☐	☐
Seasonal Allergies	☐	☐	☐
HIV	☐	☐	☐
Lupus	☐	☐	☐
Shingles	☐	☐	☐
Herpes Simplex/Zoster	☐	☐	☐
EYES			
Lazy/Turned Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Watering/Tearing	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Chronic Infection Eye/Lid	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐

***If you answered YES to any of the above or**
have a condition not listed please explain:

PATIENT SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY/INSURANCE AGREEMENT

VISION INSURANCE:
Insurance:_____ Policy Holder:_____
I.D.#:_____

MEDICAL INSURANCE:
Insurance:_____ Policy Holder:_____
I.D.#:_____

PAYMENT POLICY: If we are a participating provider in your insurance company plan, any co-pay, overage, or any other balance not paid by your insurance is required at the time of service. Payment for any materials such as glasses or contacts is due upon receipt of those materials, a deposit is required on glasses upon ordering.

PLEASE HELP US HELP YOU! It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding their own insurance policy. The insurance contract is between you and the insurance company NOT the physician and the insurance company. Our fees are not contingent on insurance allowances or slow payment and the patient is ultimately responsible to assure fee payment personally or by the insurance company. It is necessary that you provide us with your most current insurance card so we may keep a copy of it on file. Without an insurance card we may be unable to file a claim. We will not re-file a claim if the information given to us was incorrect. When purchasing materials such as glasses or contact lenses we must have the correct insurance information when an order is being placed. If you are picking up materials and the proper insurance information was not given to us at the time of the order it is your responsibility to file the claim privately.

PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE. Do we need to update any changes in your name, address, phone numbers or insurance coverage? Do you have a Medicare REPLACEMENT Plan?

The following is a list of insurances we accept: for **ROUTINE AND/OR MEDICAL:**
MEDICARE, CIGNA , UNITED HEALTH CARE, GREAT-WEST, HUMANA, VSP, EYEMED(MOST PLANS), AARP MEDICARE COMPLETE(Boulder County Direct), UMR.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARDS TO PAYMENT OF FEES FOR SERVICES RENDERED BY THIRD AVENUE EYECARE. In the event that I default, I agree to pay, whether or not legal proceedings are instituted, all collection fees, and collection costs including but not limited to, collection agency fees, court costs, and attorney fees.

PATIENT SIGNATURE: _____ **DATE:** _____

HIPPA

I have received and/or read notice of this office's Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____