THIRD AVENUE EYECARE

Name: ____ Sex: Male / Female

Social Security #:________________________ Birth Date:______________________ Age: _______________________

Phone Home:_________________________ Work: ____________________________ Cell:_______________________

Mailing Address:____ City/State/Zip: __________________________

Email Address:____

Preferred form of contact (for reminders and updates): Call / Text / Email **(circle one)**

Emergency Contact:_______________________________ Phone:______________ Relationship:__________________

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

Occupation:_________________________________ Employer:____

How were you referred to our office:____

Primary Care Physician:________________________ Phone:______________ Last Visit:_________________________

Previous Eye Dr.:_____________________________ Phone:______________ Last Visit:__________________________

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

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

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

____

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

____

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

____

<u>PATIENT</u> **EYE** HEALTH HISTORY

	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (eye turn)	☐	☐
Macular Degeneration	☐	☐
Keratoconus	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataracts Removed?	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinal Hole or Tear	☐	☐
Dry Eye Syndrome	☐	☐
Floaters	☐	☐
OTHER?	☐	☐

Please List ___________________________

<u>FAMILY</u> **HEALTH** and **EYE** HEALTH HISTORY

	YES	NO	**RELATIONSHIP**
Glaucoma	☐	☐	____________
Amblyopia (lazy eye)	☐	☐	____________
Blindness	☐	☐	____________
Keratoconus	☐	☐	____________
Cataracts	☐	☐	____________
Macular Degeneration	☐	☐	____________
Other Retinal Disorder	☐	☐	____________
Strabismus (eye turn)	☐	☐	____________
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.

<u>CIRCLE THE FOLLOWING that apply to you</u>:

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**? **YES / NO** (if ***yes*** please list):

____

____

Do you have any known **allergies? YES / NO** (if ***yes*** please list, including medications, food, and environmental):

____

____

Are you pregnant: Y / N Or Nursing: Y / N

REVIEW OF SYSTEMS

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

SYSTEM	YES	NO	?
VASCULAR/CARDIOVASCULAR			
High Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Stroke	☐	☐	☐
If **yes**, when:__________________			
EARS, NOSE, THROAT, MOUTH			
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
COPD	☐	☐	☐
Emphysema	☐	☐	☐
GASTROINTESTINAL			
Crohns Disease	☐	☐	☐
Hepatitis (**circle**) A B C	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
If **yes** what:______________			
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Arthritis	☐	☐	☐
MS	☐	☐	☐
Fibromyalgia	☐	☐	☐
INTEGUMENTARY			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
CANCER:	☐	☐	☐

Which Type: ____________________

Where:______________ When:__________

How Treated: ____________________

SYSTEM	YES	NO	?
PSYCHIATRIC			
Depression	☐	☐	☐
Dementia	☐	☐	☐
Bi-Polar Disorder	☐	☐	☐

SYSTEM	YES	NO	?
NEUROLOGICAL			
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Head Trauma	☐	☐	☐
If **yes**, what and when: ______________			
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
☐Hypothyroid ☐Hyperthyroid			
Diabetes: (if **yes**, check below)	☐	☐	☐
☐Type 1 ☐Type 2 ☐Gestational			
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
Seasonal Allergies	☐	☐	☐
Sjogrens	☐	☐	☐
HIV or AIDS (if **yes**, circle):	☐	☐	☐
Lupus	☐	☐	☐
Shingles / Zoster	☐	☐	☐
Herpes Simplex	☐	☐	☐
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 have a condition **not** listed please explain:

____

____

FINANCIAL POLICY/INSURANCE AGREEMENT

VISION INSURANCE: ________________________________ MEDICAL INSURANCE: ___________________________________

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. Should you write a check from an account with non-sufficient funds will be subject to a **$60 returned check fee per occurrence**.

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.

BY SIGNING I HAVE FILLED OUT AND READ THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE (Guardian if under 18 years of age): _____________________________________ DATE:_________________

HIPPA POLICY

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

PATIENT SIGNATURE (Guardian if under 18 years of age): _____________________________________ DATE:_________________