



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 / 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** Since: _____ **and** full-time / part-time **for** near / far / both

Do you wear **contact lenses: YES / NO** Since: _____ 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):

PATIENT EYE HEALTH HISTORY

FAMILY EYE AND HEALTH HISTORY

	YES	NO		YES	NO	RELATIONSHIP
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	Eye: Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts Removed?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Other Retinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Health: Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Hole or Tear	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type: 1 or 2 (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER?	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Please List _____			Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

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

CIRCLE THE FOLLOWING that apply to you:

SMOKING: CURRENT everyday/someday / FORMER SMOKER year quit: _____ / NEVER SMOKER

DRINKING: NON / TRIVIAL (less than 1 a day) / LIGHT (1-2 a day) / MODERATE (3-6 a day) / HEAVY (6+ a day)

REVIEW OF SYSTEMS

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

SYSTEM	YES	NO	?	SYSTEM	YES	NO	?
CONSTITUTIONAL				MUSCULOSKELETAL			
Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which Type: _____				Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where: _____ When: _____				Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How Treated: _____				Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, THROAT, MOUTH				Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY			
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Zoster/ Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE			
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: (if yes , check below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational			
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes , what and when: _____				LYMPHATIC/HEMATOLOGIC			
PSYCHIATRIC				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Large Volume Blood Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypercholesteremia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC			
Bi-Polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS (if yes , circle):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR				Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke When: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES			
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy/Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY				Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL				Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (circle) A B C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IBD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY				Excess Watering/Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

*If you have a condition **not** listed please explain

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):

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, 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:** _____

HIPAA POLICY SIGNATURE

I have received and/or read notice of this office's Notice of Privacy Practices. (Hipaa policy is posted at front desk)

PATIENT SIGNATURE (Guardian if under 18 years of age): _____ **DATE:** _____