THIRD AVENUE EYECARE

Name: ____ Sex: M / F Birth Date:______________________

Mailing Address:____ City/State/Zip: ___________________________

Preferred Phone Number: _________________ C / H / W **(circle one)** Email Address:______________________________

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

Emergency Contact:_______________________________ Phone:______________ Relationship:__________________

Occupation:_________________________________ Employer:____

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

Do you currently wear **glasses: Y / N contact lenses**: **Y / N**

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

____

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

____

PATIENT **EYE** HEALTH HISTORY

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

FAMILY EYE AND HEALTH HISTORY

		YES	NO	**RELATIONSHIP**
Eye:	Amblyopia (lazy eye)	☐	☐	__________
	Blindness	☐	☐	__________
	Cataracts	☐	☐	__________
	Glaucoma	☐	☐	__________
	Keratoconus	☐	☐	__________
	Macular Degeneration	☐	☐	__________
	Strabismus (eye turn)	☐	☐	__________
	Other Retinal Disorder	☐	☐	__________
Health:	Arthritis	☐	☐	__________
	Cancer	☐	☐	__________
	Diabetes Type: 1 or 2 (circle one)	☐	☐	__________
	High Cholesterol	☐	☐	__________
	Hypertension	☐	☐	__________
	Thyroid Disorder	☐	☐	__________

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)

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):

____

____

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

SYSTEM	YES	NO	?
CONSTITUTIONAL			
Developmental Disabilities	☐	☐	☐
Cancer	☐	☐	☐

Which Type: ______________________________________

Where:_____________________ When:_______________

How Treated: ____________________________________

SYSTEM	YES	NO	?
EARS, NOSE, THROAT, MOUTH			
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
NEUROLOGICAL			
Multiple Sclerosis	☐	☐	☐
Epilepsy	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Tumor	☐	☐	☐
Migraines	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Head Trauma	☐	☐	☐

If **yes**, what and when: _________________________

SYSTEM	YES	NO	?
PSYCHIATRIC			
Depression	☐	☐	☐
Attention Deficit	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Bi-Polar Disorder	☐	☐	☐
Dementia	☐	☐	☐
CARDIOVASCULAR			
Hypertension	☐	☐	☐
Stroke **When**: ________________	☐	☐	☐
Heart Disease	☐	☐	☐
Vascular Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
COPD	☐	☐	☐
Sleep Apnea	☐	☐	☐

SYSTEM	YES	NO	?
GASTROINTESTINAL			
Crohns Disease	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Hepatitis (**circle**) A B C	☐	☐	☐
IBD	☐	☐	☐
GENITOURINARY			
Kidney Disease	☐	☐	☐
Prostate Disease/Cancer	☐	☐	☐
Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Herpes	☐	☐	☐
Chlamydia	☐	☐	☐
MUSCULOSKELETAL			
Arthritis	☐	☐	☐
Osteoarthritis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Osteoporosis	☐	☐	☐
INTEGUMENTARY			
Eczema	☐	☐	☐
Rosacea	☐	☐	☐
Psoriasis	☐	☐	☐
Herpes Simplex/Cold Sores	☐	☐	☐
Herpes Zoster/ Shingles	☐	☐	☐
ENDOCRINE			
Diabetes: (if **yes**, check below)	☐	☐	☐
☐Type 1 ☐Type 2 ☐Gestational			
Thyroid Dysfunction	☐	☐	☐
Hormonal Dysfunction	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Large Volume Blood Loss	☐	☐	☐
Hypercholesteremia	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
HIV or AIDS (if **yes**, circle):	☐	☐	☐
Drug Allergies	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Lupus	☐	☐	☐
Sjogrens Syndrome	☐	☐	☐

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

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____

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 it will be subject to a **$60 returned check fee per occurrence**. **I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARD TO PAYMNET OR 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 costs including but limited to, collection agency fees, court cost, and attorney fees.

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:**_________________