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

	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)

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: ___________________________________			
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: _______________________			
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	☐	☐	☐
GASTROINTESTINAL			
Crohns Disease	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Hepatitis (**circle**) A B C	☐	☐	☐
IBD	☐	☐	☐
GENITOURINARY			
Kidney Disease	☐	☐	☐
Prostate Disease/Cancer	☐	☐	☐
Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Herpes	☐	☐	☐
Chlamydia	☐	☐	☐

SYSTEM	YES	NO	?
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	☐	☐	☐
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

____

____

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 **<u>Medicare REPLACEMENT</u>** 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.

<u>PATIENT SIGNATURE</u> (Guardian if under 18 years of age)**:** ______________________________ **DATE:**______________

<u>HIPAA POLICY SIGNATURE</u>

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

<u>PATIENT SIGNATURE</u> (Guardian if under 18 years of age): ____________________________________ **DATE:**________

Authorization for Release of Information

Authorized individuals

I authorize the disclosure of my personal health information to the persons listed below:

Name: ____ **Relationship**:________________________

Date of birth: _________________________________ **Phone**:_______________________________

Name: ____ **Relationship**:________________________

Date of birth: _____________________________ **Phone**:_______________________________

I understand that I have the right to revoke this consent at any time by sending a written statement to Third Avenue Eyecare, except to the extent Third Avenue Eyecare has already made a disclosure in reliance upon my prior consent.

PRINT NAME ____

SIGNATURE ____