

New Horizons Eyecare  
Patient Forms

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History:**

What is your general health status?     Excellent     Good     Fair     Poor

List all medications you are currently taking.

\_\_\_\_\_

Do you have any allergies to any medications?

Yes     No    If yes, to which? \_\_\_\_\_

What happens when taken? \_\_\_\_\_

List all major illnesses, injuries, surgeries and/or hospitalizations with the last 10 years.

\_\_\_\_\_

Are you pregnant?     Yes     No

**Ocular History:**

Date of last eye exam: \_\_\_\_\_ Do you wear glasses?  Yes  No    Contact lenses?  Yes  No

Current Eye drops \_\_\_\_\_ reason for using \_\_\_\_\_

List all current or past eye diseases, eye injuries or eye surgeries:

\_\_\_\_\_

**Family History:**    **Please circle yes or no to indicate if any you or a member of your family has or had these diseases. (Includes self, parents, grandparents, siblings or children)**

Blindness	Y / N	Self or Relation _____
Cataract	Y / N	Self or Relation _____
Glaucoma	Y / N	Self or Relation _____
Diabetes	Y / N	Self or Relation _____
High Blood Pressure	Y / N	Self or Relation _____
Cancer	Y / N	Self or Relation _____
Heart Disease	Y / N	Self or Relation _____
Thyroid Disease	Y / N	Self or Relation _____
Arthritis	Y / N	Self or Relation _____
Stroke	Y / N	Self or Relation _____
Macular Degeneration	Y / N	Self or Relation _____
Other inherited diseases	Y / N	Self or Relation _____

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**Social History:** (this information is a protected part of your medical record. It is confidential. However if you prefer, you may discuss this portions of your history directly with the doctor).

Does your vision limit activities of daily living? (driving, reading, working, etc.)  Yes  No  
If yes please describe. \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed

Living arrangements:  Live alone  Live w/Spouse  Live w/parents  Live w/children  
 assisted living  nursing home  other

Employment status: employed self employed retired homemaker med. Disability unemployed

Do you drink alcohol?  Yes  No If yes amount and how often? \_\_\_\_\_

Do you use tobacco products?  Yes  No if yes, packs per week? \_\_\_\_\_

Do you use illegal drugs?  Yes  No if yes, what type? \_\_\_\_\_

Please check any of the following diseases that you have been exposed to or infected with:

HIV  Hepatitis  Tuberculosis  Chlamydia  Gonorrhea

**Review of Systems:**

Please circle yes or no to indicate if you currently have any problems in the following areas. If yes, please explain or describe the problem.

Eyes (blurred vision, eye pain, discharge, etc.) Yes / No \_\_\_\_\_

Ears, nose, throat, mouth Yes / No \_\_\_\_\_

Respiratory (asthma, emphysema, bronchitis etc.) Yes / No \_\_\_\_\_

Cardiovascular (diabetes, hypertension, heart, etc) Yes / No \_\_\_\_\_

Genitourinary (painful urination, jaundice etc.) Yes / No \_\_\_\_\_

Lymphatic (anemia, bleeding problems, etc.) Yes / No \_\_\_\_\_

Musculoskeletal (arthritis, joint, muscle pain etc.) Yes / No \_\_\_\_\_

Skin (acne, warts, growths, rashes etc.) Yes / No \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Patient's Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Please circle African/American Caucasian Hispanic Asian Other

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer/ School \_\_\_\_\_ Position/ Grade \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

E-Mail Address \_\_\_\_\_ May we contact you by E-Mail  yes  no

**Insurance Information:**

Insurance Company \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Contract or ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Other Information**

Name of Primary Care Physician \_\_\_\_\_ phone # \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ by Dr. \_\_\_\_\_

**OFFICE PRIVACY POLICY**

I acknowledge that I have read this summary of the NOTICE OF PRIVACY PRACTICES and know that I may receive a copy to keep for my records if I choose. I understand that this office may use and disclose necessary personal health information to another party, to permit this office to perform its administrative duties, provide me with eye care services, process my insurance benefits claims and communicate with me regarding vision care services provided by this office and by LensCrafters. I can be assured that this office will not sell my personal health information to a third party.

**FINANCIAL RESPONSIBILITY**

In the event that my insurance plan sponsor determines that I am not eligible at the time of services, or that I am only eligible for a reduced level of coverage, I agree to be financially responsible for any charges incurred that are not covered by my insurance plan.

Patient Name \_\_\_\_\_

Patient /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Dilation Consent**

DILATION: Your doctor may recommend a pupil dilation, for certain vision disorders or symptoms of eye disease. I agree to the procedure and understand that there is no additional charge.

Patient /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Contact Lens Patients**

The contact lens evaluation fee is in addition to exam fees, and includes all follow-up visits for 30 days. Contact lens prescriptions will only be released after the fitting and evaluation period is successful. After 30 days, if no contact lens follow-up has been performed, office visit charges will be applied.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_