EYECARE OF ANKENY

NEW PATIENT WELCOME FORM

Welcome! Thank you for choosing us for your eyecare needs. Please complete this form; ask us for assistance if needed. All information will remain confidential.

PATIENT DEMOGRAPHICS

SSN: _____ DATE: _____

_____ _____ _____ _____ _____

FIRST NAME MI LAST NAME PREFERRED NAME/ NICKNAME PREFERRED PRONOUNS

DATE OF BIRTH: _____ GENDER: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other ☐ Decline

RACE:
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White ☐ Asian ☐ Self-describe: _____

ETHNICTIY:
- ☐ Hispanic or Latino/a/x
- ☐ Not Hispanic or Latino/a/x
- ☐ Decline

PRIMARY LANGUAGE:
- ☐ English ☐ Other: _____
- ☐ Spanish

MARITAL STATUS:
- ☐ Single ☐ Divorced ☐ Other
- ☐ Married ☐ Widowed

PREFERRED COMMUNICATION: ☐ Phone ☐ Text ☐ Email ☐ US Mail

ADDRESS: _____

_____ _____ _____ _____

ADDRESS CITY STATE ZIP

PHONE NUMBER: _____ EMAIL ADDRESS: _____

EMPLOYER/SCHOOL: _____ OCCUPATION/GRADE: _____ ☐ Full-time ☐ Part-time

MINORS ONLY:

PARENT/GUARDIAN: _____ ADDRESS _____

PHONE #: _____ WORK PHONE #: _____ EMPLOYER: _____

PARENT/GUARDIAN: _____ ADDRESS _____

PHONE #: _____ WORK PHONE #: _____ EMPLOYER: _____

What is the main reason for your visit today? _____

Date of last **eye** exam/office: _____

Date of last **medical** exam: _____ Primary care physicain/office: _____

Do you wear **glasses**? ☐ No ☐ Yes, they are ___ years old. They help me to see: ☐ distance ☐ near ☐ both

Do you wear **contact lenses**? ☐ No ☐ Yes, I wear them for ___ hours per day. They help me to see: ☐ distance ☐ near ☐ both

Contact lens type/brand: _____ Are you happy with your current **contact lenses**? ☐ Yes ☐ No

CURRENT SYMPTOMS

Check all that apply.

- ☐ **NONE**
- ☐ Blurred vision
- ☐ Eye injury
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Burning eyes
- ☐ Itching eyes
- ☐ Tearing/watering eyes
- ☐ Discharge from eye
- ☐ Eye pain
- ☐ Severe light sensitivity
- ☐ Frequent headaches
- ☐ Poor night vision
- ☐ Bothersome night glare
- ☐ Double vision
- ☐ Total loss of vision
- ☐ Floaters in vision
- ☐ Flashes of light in vision
- ☐ Other _____

EYE CONDITIONS

Have **you** ever been diagnosed with any of the following?

- ☐ **NONE**
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Diabetic retinopathy
- ☐ Chronic dry eyes
- ☐ Chronic red eyes/uveitis
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (lazy eye)
- ☐ Keratoconus
- ☐ Retinal detachment
- ☐ Other _____

EYE SURGERIES

Have **you** ever had surgery for:

- ☐ **NONE**
- ☐ Cataract
- ☐ Retinal detachment
- ☐ Eye muscle surgery
- ☐ Eye injury/foreign body
- ☐ Corneal transplant
- ☐ LASIK/PRK
- ☐ Other _____

MEDICAL CONDITIONS

Are **you** currently diagnosed with any of the following?

- ☐ **NONE**
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
  - Last A1c%: _____ Date: _____
  - Blood sugar ranges: _____
  - Year diagnosed: _____
- ☐ High blood pressure
- ☐ Heart disease or stroke
- ☐ High cholesterol
- ☐ Chronic allergies
- ☐ Lung disease
- ☐ Asthma/COPD
- ☐ Thyroid dysfunction
- ☐ Arthritis
- ☐ Colitis
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Cancer: _____
- ☐ Other _____

MEDICATIONS

List all current medications, vitamins, supplements & eyedrops

Allergies to medications?: ☐ No known drug allergies ☐ Yes, list below

Please list known allergies: _____

(Females) Are you pregnant/breastfeeding? ☐ No ☐ Yes, pregnant ☐ Yes, breastfeeding

SOCIAL HISTORY

Alcohol use: ☐ Yes ☐ No

Tobacco use: ☐ Yes ☐ No

Recreational drug use: ☐ Yes ☐ No

HEIGHT _____

WEIGHT _____

FAMILY HISTORY

Has anyone in your **family** had:

RELATIONSHIP

- ☐ **NONE**
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ Macular Degeneration _____
- ☐ Glaucoma _____
- ☐ Blindness _____

PATIENT NAME: _____ **DATE:** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from EyeCare of Ankeny.

_____ _____

Signature of Patient/Parent/Legal Guardian/or Representative **Relationship to patient**

NON-COVERED SERVICES

I understand that I am responsible for fees not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

AUTHORIZATION TO RELEASE INFORMATION

I authorize my insurance company to release information regarding my coverage to EyeCare of Ankeny. I authorize agents of any hospital, or previous doctors to furnish EyeCare of Ankeny copies of any records of my medical history, services or treatments. I authorize the release of any medical information and/or reports related to my treatment to any doctor, optical supplier, pharmacy, or insurance company as needed or requested by me. I agree to a review of my records for purposes of internal audits, research, and quality assurance review within EyeCare of Ankeny.

ASSIGNMENT OF BENEFITS

My right to payment for all procedures, test, supplies, and technical/physician services including major medical benefits are hereby assigned to EyeCare of Ankeny. This assignment covers any and all benefits under/over Medicare, other government sponsored programs, private insurance and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance company does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to EyeCare of Ankeny.

I have read the above statements and accept the terms. I understand that I may revoke this consent, in writing, at any time.

_____ _____

Signature of Patient/Parent/Legal Guardian/or Representative **Relationship to patient**

Contact Lens Prescription Acknowledgement

I acknowledge that I will be provided with a copy of my contact lens prescription at the completion of my contact lens fitting.
I acknowledge that there will be a fee for the contact lens fitting from $48.00 - $88.00.

_____

Signature of Patient/Parent/Legal Guardian/or Representative

Place a check mark in the box below next to the person or persons designated as your EMERGENCY CONTACT
The following individuals have my authorization to access my Protected Health Information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ ☐ _____ _____

Name Relationship Phone

_____ ☐ _____ _____

Name Relationship Phone