Precision Eye Care New Patient Intake Form

Last Name_____ First_____ MI_____ Sex ___M ___F

Address_____ City_____State_____ Zip_____

Home phone ( )_____ Work phone ( )_____ Cell phone ( )_____

Date of Birth_____ S.S. # _____-_____-_____

Email_____ Emergency name/number: _____

Occupation_____ Employer _____

Health Information Preferred Pharmacy:_____

Reason for visit: Exam for glasses___ Exam for glasses & contacts___ Eye Infection/Injury___

Last Eye Exam _____Dr. Name_____

Do you wear contacts? _____YES____NO If so, what brand?_____

How did you hear about us?_____

Have you had any surgery or injury to or around your eyes? _____ If yes, explain_____
_____

Who is your primary care physician?_____Last visit:_____

List any medications you are currently taking: _____

_____

Medication Allergies:_____

Height:_____ Weight:_____ Are you pregnant? No_____ Yes_____

Health History Please note any family history (**parents, siblings**, etc living or deceased)

	You	Mother	Father	Relative		You	Mother	Father	Relative
Glaucoma									
Cataracts					High Blood Pressure				
Eye turn					Low Blood Pressure				
Blindness					High/Low Blood Sugar				
Retinal Disorder					Asthma/Bronchitis				
Color Blindness					Thyroid Disorder				
Macular Degeneration					Cancer/Tumor				
Kidney/ Liver Disorder					Heart/ Vascular Disorder				
Cholesterol					Seasonal Allergies				
G.I. Disorder					Other				
Arthritis					Diabetes				
Fainting/Dizziness					Last A1c/sugar #				

Social History Do you use tobacco products? Y N If yes, type/amount/how long?_____
Are you a _____former _____ occasional _____ every day smoker. Do you use alcohol products? Y N

DILATION: It is our goal to provide you a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil (black spot) and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading (in most cases the distance vision will be unaffected). The side effects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may not want to, defer or omit this procedure**.** ***Please indicate your preference below:***

_____ I wish to be dilated today

_____ I do not wish to be dilated and agree to hold Dr. Cremata/Dr. Reed West harmless as a result of my actions

Payment for the doctor is required at time of service

The following forms of payment are accepted: Cash, Check, Mastercard and Visa. If you are paying by check, we require a valid driver's license. Returned checks will be assessed a $25.00 service charge.

Insurance Billing: (your signature below allows us to bill your insurance company)

I request that payment of authorized Vision and/or medical insurance benefits either to me or my behalf be made to Dr. Cremata for any services furnished me by the doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

I also understand that if my insurance company does not provide payment to Dr. Cremata, I will be billed for and agree to pay for said service.

Insurance Information

Do you have vision insurance? Y N If yes, carrier_____

Do you have health insurance? Y N If yes, carrier_____

Do you have Medicare? Y N

Member ID/Policy Number_____

Policy holder's Name (if not the patient)_____

Policy holder's Date of Birth_____Policy holder's Employer_____

Relationship to Patient_____

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____