New Patient Intake Form

1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. **Primary Vision Insurance**

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

3. **Primary Medical Insurance**

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

4. **Secondary Insurance**

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

5. **How did you learn about our practice or whom may we thank for referring you?**

_____

_____

_____

_____

6. If you weren't referred, how did you hear about our office?

7. Reason for today's visit (your primary concern):

8. Your secondary concerns:

9. Is there anything else you would like us to know before your visit?:

10. Your physician: Date of last visit:

11. Women

Are you pregnant?
○ Yes ○ No

Are you nursing?
○ Yes ○ No

Are you taking birth control?
○ Yes ○ No

12. Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ q Tuberculosis
- ☐ Ulcer

13. Check if you have or have had any of the following vision problems:

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Keratoconus
- ☐ Retinal Detachment
- ☐ Uveitis
- ☐ Strabismus (Eye Turn)
- ☐ Amblyopia (Lazy Eye)
- ☐ Color Blind
- ☐ Blind
- ☐ Retinitis Pigmentosa
- ☐ Floaters
- ☐ Nearsightedness
- ☐ Farsightedness
- ☐ Astigmatism
- ☐ Presbyopia
- ☐ Other, please describe below

14. Please list all eye surgeries and their dates below.

_____

_____

_____

_____

15. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		
2		
3		
4		

16. Supplements now or in the recent past:

	Name of supplement	Dosage	Duration	Benefits	Side effects
1					
2					

17. Please list any allergies you may have:

	Allergy
1	
2	
3	
4	

18. Habits and Lifestyle

Do you smoke?
☐ Yes ☐ No
If 'yes', what? _____
How much per day? _____
Since when? _____

Do you drink alcohol?
☐ Yes ☐ No
If 'yes', what? _____
How much? _____
How often? _____

Do you drink soda pop?
☐ Yes ☐ No
If 'yes', what type?
○ Regular ○ Diet
How much? _____
How often? _____

Do you exercise regularly?
☐ Yes ☐ No
If 'yes', please describe what you do. _____

Financial Policy

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the practice regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. We also ask that materials be paid for before they are ordered._____

Provider Claims

I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for related services. Payment from my insurance company is to be paid directly to Bradford County Eye Center. I understand that the insurance I provide will be billed as by primary insurance. I understand billing any second insurance is my responsibility. I understand all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed._____

Privacy Policy

I acknowledge that I received a copy of Bradford County Eye Center's revised notice of privacy practices.

_____

Cancellation Policy

A $25 fee is charged for failure to give a 24 hour notice to reschedule or cancel your appointment.

_____

Refraction

Our office fee for a refraction (spectacle evaluation) is $30 and this fee is collected at the time of service in addition to any co-payment your plan may require. This is a non-covered service with most medical plans including Medicare. Vision plans typically cover this charge. _____

Notice of Polycarbonate for Minors and Monocular Patients

We strongly recommend that all patients under 18 or who or blind in one eye get polycarbonate lenses with their glasses. Polycarbonate is an impact resistant material that is needed for safety reasons for minors.

_____

_____ _____

Client Signature Date