Patient Name:_____ Date:_____/_____/_____
Last First MI

(If patient is younger than 18 years old, please include parent/guardian name in parenthesis)

Address: _____
Street City State Zip Code

Telephone # (home) _____-_____-_____ (work) _____-_____-_____ (cell) _____-_____-_____

Occupation_____ SS#: _____ E-mail _____

Circle: Male Female Other* ETHNICITY: Caucasian Hispanic African-American Asian Other_____
Date of Birth _____/_____/_____ Last Eye Exam _____/_____ Last Medical Exam _____/_____

Insurance Holder's Name: _____Date of birth: _____/_____/_____
Last First MI

MEDICAL INSURANCE** Primary: Secondary:	VISION INSURANCE
REASON FOR TODAY'S VISIT	HOW DID YOU HEAR ABOUT OUR OFFICE?

Do you wear glasses? Y N Do you wear contact lenses? Y N If yes, are they comfortable? Y N
Do you sleep in your contacts? Y N If yes, how many nights in a row?__ Are you willing to try a daily disposable? Y N

CURRENT EYE PROBLEMS	Yes	No
Burning/Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Excess Tearing/Watering	☐	☐
Flashing lights	☐	☐
Floaters or Spots	☐	☐
Dryness	☐	☐
Redness	☐	☐
Eye Pain or Soreness	☐	☐
Foreign Body Sensation	☐	☐
Infection of Eye or Lid	☐	☐
Glare/Light sensitivity	☐	☐
Mucous Discharge	☐	☐
Headaches	☐	☐

CURRENT EYE PROBLEMS	Yes	No
Blurred vision distance/near	☐	☐
Drooping Eyelid	☐	☐
Distorted Vision (halos)	☐	☐
Double Vision	☐	☐
Fluctuating Vision	☐	☐
Loss of Vision/Side Vision	☐	☐
Glaucoma	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Lazy eyes/crossed eyes	☐	☐
Eye surgeries	☐	☐

Other_____

YOUR MEDICAL HISTORY	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
Thyroid	☐	☐
Respiratory (Asthma)	☐	☐
Gastrointestinal	☐	☐
Kidney	☐	☐
High Cholesterol	☐	☐

List any medications you are taking:
_____
_____

YOUR MEDICAL HISTORY	Yes	No
Skin (Eczema, Rosacea)	☐	☐
Neurological (MS)	☐	☐
Anxiety, Depression	☐	☐
Muscles, Bones, Joints	☐	☐
Ears, Nose, Throat	☐	☐
Blood/Lymph	☐	☐
Allergic/Immunologic	☐	☐
Heart disease	☐	☐

Other:_____
_____

FAMILY HISTORY
Circle any conditions related to your family:

Lazy Eye
Blindness
Cataracts
Color Blindness
Glaucoma
Macular Degeneration
Retinal Detachment
Eye Turn
Arthritis
Cancer
Diabetes
Heart Disease
High Blood Pressure
Kidney Disease
Lupus
Strokes
Thyroid

TURN OVER

SOCIAL HISTORY

Do you use tobacco products? YES NO If yes, type/amount/how long _____
Do you drink alcohol? YES NO If yes, type/amount/how long_____
Do you use recreational drugs? YES NO If yes, type/amount/how long _____
Do you have any allergies to medications? _____

DILATION VS. RETINAL PHOTO INFORMATION

IMPORTANT! PLEASE READ ABOUT RETINAL PHOTOS NOW OFFERED AT INSIGHT EYECARE!

Insight Eyecare now offers digital retinal imaging which is a retinal photo. This device takes a high-definition picture of the back of your eye (retina). It can sometimes give the doctor even more information than a traditional dilation that uses eye drops. It takes only 5 minutes, has no side effects, and typically requires just a copay of $39 or $55 depending on your insurance. Please indicate your preference:

_____I prefer the retinal photo. ($39-$55 copay)
_____I prefer my eyes be dilated with traditional drops and understand this may cause blurry vision for reading for at least 2 hours afterward. I understand that I may have to come back on another day to have this test done.

WE RECOMMEND HAVING THE RETINAL PHOTO TEST DONE EVERY YEAR.

Patient/Parent signature _____ Date_____
When was the date of your last pupil dilation?_____

The fee for DILATION with dilating drops is $55 if it is not covered with medical insurance.

CONTACT LENS POLICY

Contact lenses are medical devices. New Jersey state law mandates that at least one follow up visit is required after the initial exam to evaluate the contact lenses. Should you need more than TWO follow up visits, it will be at the Doctor's discretion to charge for a follow up visit which is $25.00

All follow up visits need to be completed within TWO months (8 weeks) of the initial exam.
A fee of $25 will be charged if the follow up visit is between 2-4 months.
A fee of $50 will be charged if the follow up visit is between 5-6 months.
A new contact lens exam will be required after 6 months and FULL fee for the exam will be charged.

Patient/Parent signature _____Date_____

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*REGARDING GENDER:
This information is required for communicating with your insurance company. We also use it for medical reference. Some eye disorders are more common in males than females, for example. If you would like to provide more details on your gender identity, including preferred pronouns, you may use the line below. This information will not be shared outside this office. Insight Eyecare is committed to making sure every patient feels welcome and respected.

_____

**REGARDING INSURANCE:
We do not participate in all vision or medical plans. It is your responsibility to provide us with your insurance information when you make the appointment and/or arrive for your appointment. Most insurance companies require pre-authorization. If you do not provide this information upon arrival, then you are responsible for all fees, deductibles, co-pays and any extras not covered by your insurance. All payments are due at the time of your appointment because we do not routinely bill or mail statements.

TURN OVER