THIRD AVENUE EYECARE

Name: ______________________________ Sex: Male / Female

Social Security #:________________ Birth Date:________________ Age: ________________

Phone Home:________________ Work: ________________ Cell:________________

Mailing Address:______________________________ City/State/Zip: ____________

Email Address:______________________________

Would you like to receive text message notifications? Y / N

Race: (circle) American Indian Asian Black/African American Caucasian Hispanic Pacific Islander Other Decline

Occupation:________________Employer:________________

How were you referred to our office:______________________________

Primary Care Physician:________________ Phone:__________ Last Visit:________________

Previous Eye Dr.:________________ Phone:__________ Last Visit:________________

Do you wear **glasses: YES / NO** how long ________ ***and*** full-time / part-time ***for*** near / far / both

Do you wear **contact lenses**: **YES / NO** how long ________ soft / gas perm / specialty __________

PATIENT **EYE** HEALTH HISTORY

	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (eye turn)	☐	☐
Macular Degeneration	☐	☐
Keratoconus	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataracts Removed?	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinal Hole or Tear	☐	☐
Dry Eye Syndrome	☐	☐
Floaters	☐	☐
OTHER?	☐	☐

Please List ____________________

FAMILY **HEALTH** and **EYE** HEALTH HISTORY

	YES	NO	**RELATIONSHIP**
Glaucoma	☐	☐	________
Amblyopia (lazy eye)	☐	☐	________
Blindness	☐	☐	________
Keratoconus	☐	☐	________
Cataracts	☐	☐	________
Macular Degeneration	☐	☐	________
Other Retinal Disorder	☐	☐	________
Strabismus (eye turn)	☐	☐	________
Arthritis	☐	☐	________
Cancer	☐	☐	________
Diabetes	☐	☐	________
Thyroid Disorder	☐	☐	________
High Cholesterol	☐	☐	________
Hypertension	☐	☐	________

Do you have any **CURRENT EYE** issues:

Blurred vision	☐	☐
Dryness	☐	☐
Burning	☐	☐
Itching	☐	☐
Floaters	☐	☐
Flashes of light	☐	☐
Halos	☐	☐
Sandy/Gritty feeling	☐	☐
Glare	☐	☐
Eye Pain	☐	☐
Eye Fatigue	☐	☐
Double vision	☐	☐

Other Symptoms not listed? ______________________________

Have you had any **EYE** surgeries? **YES / NO** (If ***yes***, what, which eye, when): ____________________

Have you had any other surgeries? **YES / NO** (If ***yes*** what and when): ____________________

REVIEW OF SYSTEMS

Do **you** currently, or have you ever had any problems in the following area:

SYSTEM	YES	NO
CONSTITUTIONAL		
Developmental Disability	☐	☐
Cancer	☐	☐
Type_________________________________		
How treated: _________________________		
When:_______________Where:______________		
EARS, NOSE, THROAT, MOUTH		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry throat/mouth	☐	☐
NEUROLOGICAL		
MS	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Migraines	☐	☐
Autism Spectrum Disorder	☐	☐
Head Trauma	☐	☐
If yes what and when: _________________________		
PSYCHIATRIC		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bi-Polar Disorder	☐	☐
Dementia	☐	☐
CARDIOVASCULAR		
Hypertension	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐
Stroke	☐	☐
If yes when:_________________________________		
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Sleep Apnea	☐	☐
GASTROINTESTINAL		
Crohn's Disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Hepatitis (**circle**) A B C	☐	☐
IBD	☐	☐
GENITOURINARY		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐

SYSTEM	YES	NO
MUSCULOSKELETAL		
Arthritis	☐	☐
Osteoarthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
INTEGUMENTARY		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
ENDOCRINE		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Large Volume Blood Loss	☐	☐
Hypercholesterolemia	☐	☐
ALLERGIC/IMMUNOLOGIC		
HIV or AIDS (**if yes**, circle)	☐	☐
Drug Allergies	☐	☐
Seasonal Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐

Other condition not listed? ________________________
____
____

ARE YOU CURRENTLY **PREGNANT**? Y / N

ARE YOU CURRENTLY **NURSING**? Y / N

Do you take any **medications** or **supplements**? **YES / NO** (if ***yes*** please list):

____

____

Do you have any known **allergies? YES / NO** (if ***yes*** please list, including medications, food, and environmental):

____

____

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this portion directly with your doctor if you prefer.

CIRCLE THE FOLLOWING that apply to you:

1. **SMOKING**: CURRENT everyday/someday **/** FORMER SMOKER year quit: _________ **/** NEVER SMOKER
2. **DRINKING**: NON **/** TRIVIAL (less than 1 a day) **/** LIGHT (1-2 a day) / MODERATE (3-6 a day) / HEAVY (6+ a day)

FINANCIAL POLICY/INSURANCE AGREEMENT

VISION INSURANCE ________________________________ **MEMBER NUMBER** ___________________________

MEDICAL INSURANCE ______________________________ **MEMBER NUMBER** ___________________________

PAYMENT POLICY: If we are a participating provider in your insurance company plan, any co-pay, overage, or any other balance not paid by your insurance is required at the time of service. Payment for any materials such as glasses or contacts is due upon receipt of those materials, a 50% deposit is required on glasses upon ordering. Should you write a check from an account with non-sufficient funds will be subject to a **$60 returned check fee per occurrence**.

PLEASE HELP US HELP YOU! It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding their own insurance policy. The insurance contract is between you and the insurance company NOT the physician and the insurance company. Our fees are not contingent on insurance allowances or slow payment and the patient is ultimately responsible to assure fee payment personally or by the insurance company. It is necessary that you provide us with your most current insurance card so we may keep a copy of it on file. Without an insurance card we may be unable to file a claim. We will not re-file a claim if the information given to us was incorrect. When purchasing materials such as glasses or contact lenses we must have the correct insurance information when an order is being placed. If you are picking up materials and the proper insurance information was not given to us at the time of the order it is your responsibility to file the claim privately.

PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE.

The following is a list of insurances we accept: for **ROUTINE AND/OR MEDICAL:**
MEDICARE, CIGNA (most plans) , ANTHEM BLUE CROSS BLUE SHIELD, UNITED HEALTH CARE, GREAT-WEST, HUMANA, VSP, EYEMED(MOST PLANS), AARP MEDICARE COMPLETE(Boulder County Direct), MEDICARE ADVANTAGE, UMR

Medical insurance **DO NOT** accept: AETNA, CIGNA CONNECT, CIGNA LOCAL PLUS

I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARDS TO PAYMENT OF FEES FOR SERVICES RENDERED BY THIRD AVENUE EYECARE. In the event that I default, I agree to pay, whether or not legal proceedings are instituted, all collection fees, and collection costs including but not limited to, collection agency fees, court costs, and attorney fees.

PATIENT <u>OR</u> GUARDIAN SIGNATURE: ________________________________ **DATE:**______________

BY SIGNING I HAVE FILLED OUT AND READ THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE.

HIPAA POLICY

I have received and/or read notice of this office's Notice of Privacy Practices (policy is posted in your exam room)

PATIENT OR GUARDIAN SIGNATURE: ______________________________________ **DATE:**__________________

EMERGENCY CONTACT

Please list a person to contact **in the case of an emergency**

Name ____________________________ Relationship______________________ Phone number_________________

AUTHORIZED INDIVIDUALS

I authorize the disclosure of my personal health information to the **persons listed below**:

Name: _______________________________________ **Relationship:**________________________

Phone:_______________________________________

Name: _______________________________________ **Relationship:**________________________

Phone:_______________________________________

I understand that I have the right to revoke this consent at any time by sending a written statement to Third Avenue Eyecare, except to the extent Third Avenue Eyecare has already made a disclosure in reliance upon my prior consent.

PRINT NAME ____

SIGNATURE ____

DATE ____