CARY FAMILY EYE CARE

New Patient Information

Patient's First Name: _____ Last Name: _____

Address: _____ City_____ State_____ Zip_____

Date of Birth: _____ Gender: M / F Marital Status: S / M / D / W Last 4 of SSN: _____

Home: (_____) _____ Cell: (_____) _____ Email: _____

Occupation (or Grade) _____

Communication Preference (Please Circle): Phone / Email / Postal

Race (Please Circle): Black - African American / Native American / Asian / Hawaiian or Other Pacific Islander / Hispanic / White / Decline to Answer

Ethnicity (Please Circle): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Insurance Information

Please Note: Most Vision Plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems fall under your medical coverage. If you have any questions about your coverage. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

By signing below, you are authorizing Cary Family Eye Care to bill your insurance for services provided and to release all necessary medical information to process the claim. You authorize payment to be made directly to Cary Family Eye Care. **The insurance carrier presented at the time of service will be the only insurance billed. No exceptions can be made.** If your insurance company has not reimbursed our office in full within 90 days, you will be billed for your visit.

Signature: _____ **Date: _____**

Pupil Dilation

A thorough exam with dilation is often the first step in diagnosing a condition that could possibly have devastating effects on your vision. Drops are used to give your doctor a larger view of the inside of your eye and retina periphery. We look for tumors, retinal detachments, macular degeneration, and other diseases or defects. You may experience light sensitivity and decreased near vision for 2-6 hours. We will supply you with disposable sunglasses for your comfort.

Initial: _____ I accept dilation today **Initial:** _____ I do NOT accept dilation today

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I am familiar with the privacy policy statement of Cary Family Eye Care.

Signature: _____

Ocular History

Date of last eye exam? _____ Previous Eye Doctor: _____

Have you recently experienced, been diagnosed with, or treated for any of the following:

☐Blurry Vision ☐Cataracts ☐Floaters/Spots ☐Trouble seeing at night ☐Eye Injury

☐Iritis/Uveitis ☐Headaches ☐Corneal Abrasions ☐Crossed eye/Eye turn ☐Double Vision

☐Flash of light ☐Glaucoma ☐Sunlight Sensitivity ☐Macular Degeneration ☐Retinal Detachment

List any vision complaints you are having: _____

_____

Medical History

Primary Physician: _____ Physician Telephone: _____ Last Physical Exam: _____

Have you ever been diagnosed or treated for the following health problems:

☐Allergies ☐Arthritis ☐Blood/Lymph ☐Cancer ☐Cholesterol ☐Diabetes Mellitus

☐Digestive ☐Ears/Nose/Throat ☐Genitourinary ☐High Blood Pressure ☐Integumentary (Skin)

☐Kidney ☐Neurological ☐Psychological ☐Respiratory ☐Thyroid ☐Other

List any surgeries, including eye surgeries you have had: _____

_____

List medications (Rx and over-the-counter) you take: _____

_____

List all allergies to medications: _____

List all non-medication allergies: _____

Family Medical/Eye History

Check any conditions that apply:

	Mother	Father	Sister	Brother	Grandparents	Other (please indicate)
Blindness	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐
Corneal Problems	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Lazy Eye/Ambliopia	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Retinal Problems	☐	☐	☐	☐	☐	☐

Smoking History: ☐ Never ☐ Former Smoker ☐ Some Days ☐ Every Day

Alcohol Use: ☐ Never ☐ Occasional ☐ Social ☐ 1 Drink/day ☐ 2+Drinks/day