NORWOOD FAMILY EYE CARE

Patient's Name First, Middle Initial, Last			Date:	
SSN:			DOB:	
Gender:	□MALE □FEMALE	Race:		
Ethnicity:	□ Hispanic or Latino		□ NOT Hispanic or Latino	
Address:			Address 2:	
City:	State:		Zip:	
Email Address:				
Home Phone:		Cell Phone:		
□Employed □Not Student □ Full Time Student □ Part Time Student				
Employer/School:		Occupation:		
Marital Status: □Single □Married □Other				
Spouse Name:		Spouse Employer:		
Referred By:				
Patient Insurance:	Vision:	Medical:		
Member Name:		Member DOB: Member SSN:		
VISUAL AND MEDICAL HISTORY				
Reason for today's Visit?				
Date of last Exam?			By Whom:	
Do you presently wear?	□ Glasses	□ Contacts	□ Both □ Neither	
If not wearing contacts, are you interested in trying them today?				□ YES □ NO
If you wear contact lenses, do you know what type or brand?				
Are you contacts comfortable?	□ YES □ NO			
How old are your glasses?		How old are your contacts?		
Name of your Medical Doctor:		Dr's Phone:		
Are you currently Taking any medications? Including oral contraceptives, aspirin, otc and/or herbal meds) If so, please list:				
Do you have any allergies to any medications:		□ YES □ NO		
If so, please list:				
List all surgeries and/or hospitalizations you have had:				
Are you pregnant or nursing:		□ YES □ NO		
Please List:	Your height in inches:		Your weight in lbs:	

REVIEW OF SYSTEMS

Do YOU currently, or have you ever had any problems in the following areas:

Constitutional		
Fever, Weight Loss/Gain	□YES	□NO
Other: ________	□YES	□NO
Integumentary (Skin)	□YES	□NO
Other: ________	□YES	□NO
Neurological		
Headaches	□YES	□NO
Migraines	□YES	□NO
Seizures	□YES	□NO
Other: ________	□YES	□NO
Eyes		
Loss of Vision	□YES	□NO
Blurred Vision	□YES	□NO
Distorted Vision/Halos	□YES	□NO
Loss of Side Vision	□YES	□NO
Dryness	□YES	□NO
Mucous Discharge	□YES	□NO
Sandy or Gritty Feeling	□YES	□NO
Foreign Body Sensation	□YES	□NO
Glare/Light Sensitivity	□YES	□NO
Chronic Eye/Lid Infection	□YES	□NO
Styes or Chalazia	□YES	□NO
Flashes/Floaters	□YES	□NO
Tired Eyes	□YES	□NO
Itching	□YES	□NO
Excess Tearing/Watery	□YES	□NO
Other: ________	□YES	□NO
Psychiatric		
Anxiety	□YES	□NO
ADD	□YES	□NO
ADHD	□YES	□NO
Other: ________	□YES	□NO
Allergic/Immunologic		
Other: ________	□YES	□NO

Ear, Nose, Mouth, Throat		
Allergies/Hay Fever	□YES	□NO
Sinus Congestion	□YES	□NO
Runny Nose	□YES	□NO
Post-Nasal Drip	□YES	□NO
Chronic Cough	□YES	□NO
Dry Throat/Mouth	□YES	□NO
Other: ________	□YES	□NO
Respiratory		
Asthma	□YES	□NO
Chronic Bronchitis	□YES	□NO
Emphysema	□YES	□NO
Other: ________	□YES	□NO
Vascular/Cardiovascular		
Diabetes	□YES	□NO
Heart Disease	□YES	□NO
High Blood Pressure	□YES	□NO
High Cholesterol	□YES	□NO
Vascular Disease	□YES	□NO
Other: ________	□YES	□NO
Gastrointestinal		
Diarrhea	□YES	□NO
Constipation	□YES	□NO
Other: ________	□YES	□NO
Genitourinary		
Other: ________	□YES	□NO
Bones/Joints/Muscles		
Arthritis	□YES	□NO
Muscle Pain	□YES	□NO
Joint Pain	□YES	□NO
Other: ________	□YES	□NO
Lymphatic/Hematologic		
Anemia	□YES	□NO
Other: ________	□YES	□NO
Endocrine		
Thyroid/Other Glands	□YES	□NO

NORWOOD FAMILY EYE CARE

OCULAR HISTORY

Check any of the following that YOU have had:

□Crossed Eyes	□Lazy Eye	□Drooping EyeLid	□Prominent Eyes	□Glaucoma
□Retinal Disease	□Cataracts	□Eye Infections	□Eye Injury	□Double Vision
□Eye Pain	□Itching	□Tearing	□Burning	□Redness
□Floaters	□Flashes	□ Halos around lights		

Are you interested in Laser vision Correction? □ YES □ NO

Are you interested in hearing about treatments for dry eyes? □ YES □ NO

FAMILY MEDICAL HISTORY

Please Note any family history (Parents, Grandparents, Children, Siblings, living or Deceased)

Disease/Condition	YES	NO	Relationship to You
Blindness	□	□	
Cataract	□	□	
Glaucoma	□	□	
Lazy/Crossed Eyes	□	□	
Macular Degeneration	□	□	
Retinal Detachment	□	□	
Retinal Disease	□	□	
Arthritis	□	□	
Cancer	□	□	
Diabetes	□	□	
Heart Disease	□	□	
High Blood Presure	□	□	
Kidney Disease	□	□	
Lupus	□	□	
Thyroid Disease	□	□	
Other: ______	□	□	

SOCIAL HISTORY

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

□ Yes, I would prefer to discuss my Social History with the doctor

Smoking Status:	□Current everyday smoker		□ Current some day smoker		
	□Former Smoker		□Never Smoked		
Do you use tobacco products?	□YES	□NO	If yes, type/amount/how long:		
Do you use illegal drugs?	□YES	□NO	If yes, type/amount/how long:		
Have you ever been exposed to or infected with:	□Gonorrhea	□Hepatitis	□HIV	□Syhillis	□Other:

Norwood Family Eye Care, LLC

Dilation*

Pupil Dilation is a recommended part of our complete eye examination. It allows the doctor to better examine the retina for retinal detachments, holes, tumors, leaking blood vessels, and other retinal problems. Pupil dilation is recommended for all of our patients; however, dilation is especially important for our patients

- Over 40 years of age
- With high eyeglasses prescriptions
- With history of head or eye injuries
- With Diabetes, Hypertension, or Heart disease
- Who are taking certain medications

The most common side effect of the eye drops used in the dilation process are light sensitivity and blurred vision *within* arm's length. Distance vision is usually not significantly affected, so you should be able to drive. If you don't have sunglasses with you, they are provided. The process is painless and the effects last from 3-6 hours.

Signature

- ☐ **Yes, I want dilation.**
- ☐ **No, I do NOT want dilation.** ______________________________

Contacts

If you are fit for contacts, there will be a contact lens fitting fee that is required on the date of service. This fee also applies to patients who have previously worn contacts. It includes a pair of trial lenses until ordered contacts are received and also a follow-up visit if needed. A prescription will not be released until after your follow-up exam and all fitting fees have been paid.

If needed, are you interested in getting fit for contact lenses today?

- ☐ **Yes, I want to be fitted for contacts and I agree to the fitting fee.** Signature
- ☐ **No, I do NOT want to be fitted for contacts.**

____

PLEASE NOTE:

- Professional fees are NOT refundable.
- Prescription rechecks are available at no charge for 45 days from original exam by original doctor. Fees apply after 45 days or for a second opinion.
- Problem eyes not related to contact lens fit are considered a separate office visit.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. YOU MAY ALSO HAVE ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We also require by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and private practices with respect to your medical information. We are required by law to abide by the terms of this notice.

I have been presented with the Notice of Privacy Policy of NORWOOD FAMILY EYE CARE, LLC (the provider) and have been offered a copy of such policy for my records.

Signature: ______________________________

Norwood Family Eye Care, LLC

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

- ✓ I authorize the release of any medical or any other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment: NORWOOD FAMILY EYECARE, LLC.
- ✓ I authorize payment of medical/vision benefits to NORWOOD FAMILY EYE CARE, LLC for services rendered. I agree to be financially responsible for ANY BALANCE NOT PAID by insurance plan.

I certify that the information given by myself, in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Norwood Family Eye Care, LLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to centers of Medicaid and Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent.

______________________________ ____________________

Permanent Patient Signature or Patient's Representative **Date**

Printed Name of patient's representative: ____________________
Description of the Representative's authority to act for the Patient: ____________________
Relationship to Patient: ____________________