Insight Family Eye Care
New Patient Registration

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Contact Information

First Name:_____ **DOB:**_____
Last Name:_____ **Street**
Age:_____ **Gender:**_____ **Address:**_____
Daytime Phone:_____ **Suite/Apt.:**_____
Mobile Phone:_____ **City:**_____
Email:_____ **State:**_____**Zip Code:**_____

I give consent to the doctor to perform necessary testing. If patient is a child, parent or guardian must sign.
Signature:_____**Date**_____

Parent/Guardian Information (if patient is under 18 years of age)

First Name:_____ **Street Address:**_____
Last **Suite/Apt.:**_____
Name:_____ **City:**_____
Daytime Phone:_____ **State:**_____**Zip Code:**_____
Mobile Phone:_____
Email:_____

Patient Insurance Information

Vision Insurance Provider:_____ **Medical Insurance Provider**_____
ID Number/Policy Number:_____ **Provider Phone #:**_____
Group Number:_____ **Policy Number/I.D Number:**_____
Policy Holder Name:_____ **Group Number:**_____
Policy Holder DOB:_____ **Policy Holder Name:**_____
Policy Holder SSN:_____ **Policy Holder DOB:**_____
Policy Holder SSN:_____

Financial Assignment Information

I understand and agree that health/accident policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charger are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgement Notice of Privacy Practices(NPP)

- ❑ **Yes, I have read or had explained to me by this office the NPP and I wish to continue my care under said terms.**
- ❑ **No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.**
- ❑ **The NPP could not be read due to the emergent nature of the care needed.**

_____

Signature **Date**

Insight Family Eye Care
Patient History

Visual History (please check all that you are currently experiencing)

❑ Blurred vision at distance	❑ Tired eyes	❑ Loss of vision
❑ Blurred vision at near	❑ Eye strain	❑ Loss of peripheral vision
❑ Double vision	❑ Headaches	❑ Discharge
❑ Itching	❑ Eye pain and/or soreness	❑ Sensitivity to light/glare
❑ Burning	❑ Flashes of light	❑ Strabismus (crossed eye)
❑ Tearing (watery eyes)	❑ Floaters or spots	❑ Amblyopia (lazy eye)
❑ Redness	❑ Foreign body sensation	❑ I stopped wearing glasses
❑ Dryness	❑ Halos	❑ I stopped wearing contacts
❑ Sandy or gritty feeling		

Glasses History (please check all that apply)

What glasses do you own? ❑ Distance only ❑ Reading only ❑ Progressive (No line bifocals) ❑ Computer glasses ❑ Lined Bifocals ❑ Lined Trifocals	❑ Safety glasses ❑ Sports goggles/glasses ❑ Sunglasses ❑ Other:_____ How many hours a day do you spend using a computer or digital device (phone/tablet)? _____	Check any that apply ❑ Allergic to nickel (frames) ❑ Need spare glasses ❑ Need sunglasses ❑ I do not want to wear glasses ❑ Problems with glare ❑ Problems with night vision

Contact Lens History (please check all that apply)

What brand of contacts do you wear?_____ How old are your current contacts?_____ How often do you replace them?_____ What solution do you use for soaking?_____ What is your typical wearing schedule?_____	Check any that apply: ❑ I do not want to wear contacts ❑ Need spare contacts ❑ Problems with current contacts ❑ Would like to change my eye color

Family History (please check all that apply)

❑ Diabetes	❑ Respiratory Condition	❑ Psychiatric Disease	❑ Blindness
❑ High Blood Pressure	❑ Thyroid Condition	❑ Glaucoma	❑ Eye turn/lazy eye
❑ High Cholesterol	❑ Migraines	❑ Macular Degeneration	❑ Other
❑ Heart Condition			

General Medical History (please answer appropriately)

1. Date of your last eye exam? _____ 2. Primary care physician name: _____ 3. Please list all eye injuries or surgeries & dates:	4. Do you use tobacco products? ____Yes ____No 5. If so, what product, how often and for how long have you used them? _____ 6. Are you pregnant? ____Yes ____No If so, how many weeks/months?_____ 7. Are you currently nursing? ____Yes ____No 8. Please list any allergies you have.	Do you have any of the following? (please check below) ❑ Diabetes ❑ High Blood Pressure ❑ High Cholesterol ❑ Heart Disease ❑ Respiratory Condition ❑ Asthma ❑ Thyroid Condition ❑ Blood Disorder ❑ Migraines/Headaches ❑ Arthritis ❑ Autoimmune Condition ❑ Psychiatric Disease ❑ Cancer ❑ Glaucoma ❑ Macular Degeneration ❑ Crossed Eye/Lazy Eye ❑ Other:_____	Please list any medications or vitamins you are currently taking.

How did you hear about us? ____Referred by your doctor _____Referred directly _____Found us on social media
Please keep in touch with us through Facebook or Twitter and check out our website: www.InsightEyeAug.com