YOUR PRIMARY AND MEDICAL EYECARE PROVIDER

Welcome to Dr. Newman Optometry

Thank you for choosing our office. In order to provide you the best care possible we ask that you answer the questions on this and the following pages.

COMPLETE YOUR PERSONAL INFORMATION

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH _____ / _____ / _____ AGE _____ GENDER _____ F _____ M

OCCUPATION _____ **SSN** _____ _____ _____

***MARK ONE*:** ---MARRIED -- SINGLE -- DIVORCED –- MINOR **Ethnicity** _____ **Race** _____

ADDRESS: _____CITY: _____ZIP_____

CELL: ( ) _____ -_____ WORK: ( ) _____ - _____ EXT: _____

HOME PHONE: ( ) _____ - _____

EMAIL _____

Due to privacy laws will not be sold or shared with anyone. For office use only.

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____TEL ( ) _____- _____

HOW DID YOU FIND US?

_____ GOOGLE	_____ YELP	_____ INSURANCE LISTING
_____ DRIVE BY	_____ SCHOOL	_____ AD
_____ PREVIOUS PATIENT	_____ DOCTOR	_____ OTHER

WHOM MAY WE THANK FOR REFERRING YOU: _____

Vision Insurance Company and Group Number: _____Name of Primary Insured: _____

Date of Birth, Social Security of Primary Insured _____

Medical Insurance Company and Group Number: _____Name of Primary Insured: _____

Date of Birth, Social Security of Primary Insured: _____

SIGN PRIVACY PRACTICES:

I acknowledge that I have read and fully understand the Notice of Privacy Practices given to me with this form. Rev.05/16

Life time Patient/Guardian Signature: _____**DATE:** _____

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

AUTHORIZATION TO PAY MEDICAL AND OPTICAL BENEFITS DIRECTLY TO THE ATTENDING PHYSICIAN

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and / or my dependent (s) have insurance coverage and to herby authorize my carrier to pay and assign directly to Dr. Charlotte Newman, OD. All benefits if any, otherwise payable to me for services rendered. I hereby authorize the Doctor to release and obtain all information necessary to service payment of said benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance**. **If my insurance fails to pay Dr. Charlotte Newman, I agree to pay all unpaid balances.** If litigation is instituted to collect any unpaid balance, I agree to also pay all costs including reasonable attorney's fees incurred by Dr. Charlotte Newman. I understand that any description given is not a certification or guarantee of payment and it is subject to its exclusions, limitations, and provisions outlined in the plan. I understand **Benefits will be determined at the time the claim is submitted. I authorize the use of this signature on all insurance submissions.** I agree that a photographic copy of this authorization is as valid as the original.

REFRACTIONS

Refraction is the measurement of the eyes for glasses. Most Medical Insurance plans, including Medicare, do not consider this to be a medical procedure, and therefore do not provide medical insurance coverage for refraction. If you choose to have refraction, you will be required to pay a fee of **$60.00** at the time services are rendered.

NOTICE FOR ADDITIONAL TEST AND PROCEDURES

Our eye exams are very complete and detailed lasting 1/2 - 1 hour long. In event that your standard eye exam (Intermediate level) indicates further testing (such **as Dilation, Visual Field, Retinal Photos, Topography, Contact Lens Evaluation /Fitting, etc.), these tests take additional time, equipment utilization, expertise, and may require another scheduled appointment. These test have a fee that may or may not be completely covered by insurances.** If you have any question about these tests or fees, please feel free to ask.

After receiving the professional services, you are responsible to pay for these services at the time provided unless your insurance company's protocol states otherwise. **As with all our professional services we provide a super-bill to be submitted with any insurance company not regularly accepted by our office for reimbursement and your convenience**.

CONTACT LENS SERVICES

For your health and safety, FDA requires an Annual Contact Lens Evaluation. A separate fee is charged beyond the routine eye exam. We determine the fit, health and the CONDITION of the eyes with contacts in addition to changes in prescription and lens design during this process. Contact Lens Examination Fees, as with all professional fees, are non-refundable.

RETINAL PHOTOGRAPHY

Fee for Baseline Retinal Photography is **$26.00.** If there is a diagnosis made your insurance may help cover the cost. Please let us know if you choose not to have the retinal photo taken; a very highly recommended imaging for seeing the details and most current health of the retina. Retinal Photography can detect systemic conditions of the body such as high blood pressure, cholesterol, diabetes and more and is especially important for people who have: ***Headaches, Spots of flashes in vision, a Family History of Glaucoma, Diabetes, Macular Degeneration, High Blood Pressure, High Cholesterol, Arthritis, Blood Disorders or Never been examined in our office.***

OFFICE POLICY

ALL SALES ARE FINAL. Due to the personal nature of the custom products we provide **all sales are final, with no returns and refund.** The turn around time of glasses can be from 7-14 business days depending on the nature of your prescription, special finishes, and passing of our high quality control standards. Any delays you will be notified.

DELIQUENT ACCOUNTS

A 2.0% monthly interest charge will be added to balances unpaid over 30 days. In the event of default on our agreed upon payment program, you will be responsible for any collection charges that may be incurred. These may be up to 100% of the balance due. There is a **$35.00** fee for any returned checks.

APPOINTMENTS

There is a **$35.00 late cancellation** fee for appointments that are changed or cancelled within 24hrs of your appointment time.

I have read and understand and agree to the above notice.

_____	_____	_____ / _____ / _____
Lifetime Patient/ Guardian Signature	**If Minor, Print full name of Parent or Guardian**	**Date**

YOUR OCULAR - MEDICAL HEALTH HISTORY Name _____ Date _____ /_____ /_____

Main Reason for Today's Exam: ☐ **Glasses** ☐ **Contact Lens Fit** ☐ **Other**_____ **Last Eye Exam** _____ / _____ / _____

☐ **Yes** ☐ **No** Ocular Surgeries: _____

☐ **Yes** ☐ **No** Taking any Eye Drops? **Eye Drop** **Reason** **Start Date**

☐ **Yes** ☐ **No** Systemic Surgeries (including cosmetic): _____ **Last Physical Exam** _____ / _____ / _____

☐ **Yes** ☐ **No** Taking any Medications? **Medication** **Reason** **Start Date**

CONDITION	YES	NO	COMMENTS	CONDITION	YES	NO	COMMENTS
HEADACHE				ITCHING			
GLAUCOMA				BURNING			
CATARACT				DRYNESS			
MACULAR DEGENERATION				SANDY/ GRITTY FEELING			
RETINAL DETACHMENT				TEARING/ WATERING			
COLOR BLINDNESS				EYE PAIN/ SORENESS			
TIRED EYES				REDNESS			
LAZY EYES				FOREIGN BODY SENSATION			
DOUBLE VISION				LOSS OF VISION			
CROSSED EYES				LOSS OF SIDE VISION			
MUCUS DISCHARGE				FLOATERS/ SPOTS			
DROPPING EYELID				FLASHES OF LIGHT			
FLUCTUATING VISION				OTHER:			

PLEASE READ AND CHECK ONE OF THE STATEMENTS BELOW REGARDING DILATION AND RETINAL PHOTOGRAPY

A Dilated pupil examination helps insure optimal eye health. In this procedure, drops are put in the eyes to open the pupil. This allows the doctor more thoroughly examine the inside of the eye. Dilation helps to detect hidden disease in the eye, which may not cause symptoms (i.e. blurred vision or pain) but which could be vision threatening or in rare cases, life threatening. **Patients with a positive history of diabetes, high blood pressure, autoimmune disease, or cancer are especially encouraged to have dilation with every eye exam**. Dilation may hinder your ability to safely drive and your work may be impaired for up to eight hours by blurred vision, glare, or light sensitivity. Dilation may be scheduled for another day if necessary. Retinal photography does not replace dilated exam, BUT they are the most accurate imaging of your current eye health. They allow us to observe even the smallest of change from the previous exams because we can magnify the photo to make comparisons with the current retinal images.

_____ **Yes, I want my eyes to be dilated. I understand there may be an additional charge unless the procedure is covered by my insurance.**

_____ **No, I do not want my eyes to be dilated today.**

I have read and understand the above and doctor has reviewed the benefits of a dilated exam with me.

Signed (Guardian if patient is a minor): _____ DATE: _____ / _____ / _____ Rev.05/16

Office use:

Retinal Imaging explained and patient chose not to perform. Patient Signature: _____

Procedure for _____ recommended. Benefits understood and patient chose not to perform: Patient Signature: _____

REVIEW OF SYSTEMS / PAST HISTORY *please explain*

Name_____ Date ____/____/____

☐ **Yes** ☐ **No** **Allergy**
_____ Seasonal Allergies _____ ***Drug Allergies (Penicillin, Sulfa, etc.)***
_____ Environmental Allergies
_____ Food Allergies
_____Other_____

☐ **Yes** ☐ **No** **Cardiovascular**
_____ Arrhythmia
_____ Cardiovascular Disease
_____ Congestive Heart Disease
_____ Heart Murmur
_____ Cholesterol Elevated
_____ Hypertension
_____Other_____
_____ Arteriosclerosis
_____ Coagulation Disorder
_____ Chest Pain
_____ Heart Palpitation
_____Mitral Valve Prolapse
_____ Low Blood Pressure

☐ **Yes** ☐ **No** **Constitutional**
_____ Recent fever
_____ Recent weight loss or gain
_____Other_____
_____ Developmental Disorders

☐ **Yes** ☐ **No** **Endocrine**
_____ Crohn's Disease
_____ Diabetes Type I
_____ Diabetes Suspect / Type II ****A1c << 6.0 OR 6.0-7.0 OR >> 7.0***
_____ Thyroid Problem ****Hypo or Hyper***
_____ Hormone Replacement Therapy
_____ Other_____
_____ Gout

☐ **Yes** ☐ **No** **Gastrointestinal**
_____ Acid Reflux
_____ Gall Bladder Problems
_____ Ulcer
_____Other_____
_____ Hepatitis/ Jaundice
_____ Sarcoidosis
_____ Cancer: Colon / Liver

☐ **Yes** ☐ **No** **Genitourinary**
_____ Amenorrhea
_____ Menopause
_____ Uterine Cancer
_____ Kidney Stones
_____ ***Pregnant /Nursing***
_____ Other_____
_____ Syphilis
_____ Prostate Problems/Cancer
_____ Bladder Problems / Infections
____ STD- Herpetic /Chlamydia

☐ **Yes** ☐ **No** **Head / Ear/ Nose/ Mouth / Throat**
_____ Neck Problems
_____ Sinus Problems
_____ **Headache – Cluster or Migraine**
_____Other_____
_____ Sore Throat (RECENT)
_____ Hearing Loss

☐ **Yes** ☐ **No** **Hematologic / Lymphatic**
_____ Anemia
_____ Hematologic Disorder
_____ Sickle Cell Disease
_____Other_____
_____ Breast Carcinoma
_____ Lymph Node Disease
_____ Temporal Arthritis

☐ **Yes** ☐ **No** **Immunologic**
_____ AIDS
_____ Herpes Simplex
_____ HIV Simplex
_____ Mononucleosis
_____ Sjogren's Syndrome
_____ Tuberculosis
_____Other_____
_____ Cytomegalovirus Infection
_____ Herpes Zoster
_____ Lyme Disease
_____ Sarcoidosis
_____ Syphilis

☐ **Yes** ☐ **No** **Integumentary**
_____ Acne
_____ Lupus
_____ Skin Cancer
_____Other_____
_____ Dermatitis
_____ Skin Disease (Psoriasis, Eczema)

☐ **Yes** ☐ **No** **Musculoskeletal**
_____ Arthritis
_____ Osteoporosis
_____ Fibromyalgia
_____Other_____
_____ Osteoarthritis
_____ Muscular Dystrophy
_____ Lupus

☐ **Yes** ☐ **No** **Neurological**
_____ Multiple Sclerosis
_____ Seizure Disorder
_____ Parkinson's Disease
_____ Brain Tumor
_____Other_____
_____ Bell's Palsy
_____ Dyslexia
_____Headache

☐ **Yes** ☐ **No** **Psychiatric**
_____ Attention Deficit Disorder
_____ Anxiety
_____ Brain damage (Trauma)
_____ Panic Attacks
_____Other_____
_____ Alzheimer's Disease
_____ Bi- Polar
_____ Depression

☐ **Yes** ☐ **No** **Respiratory**
_____ Asthma
_____ Cancer: Lung
_____ Pneumonia
_____ Sleep Apnea
_____Other_____
_____ Bronchitis
_____ COPD
_____ Emphysema
_____ Sarcoidosis

Family History – If yes, who??? **M**om / **D**ad / **S**ibling/ **M**aternal- **P**aternal -**G**rand**M**other- **G**rand**F**ather?

☐ **Yes** ☐ **No** Glaucoma, who _____
☐ **Yes** ☐ **No** Retinal Detachment, who _____
☐ **Yes** ☐ **No** Color Blindness, who _____
☐ **Yes** ☐ **No** Macular Degeneration, who _____
☐ **Yes** ☐ **No** Lazy Eye/ Crossed Eye, who _____
☐ **Yes** ☐ **No** Other_____

☐ **Yes** ☐ **No** Diabetes, who _____
☐ **Yes** ☐ **No** Thyroid, who _____
☐ **Yes** ☐ **No** High Blood Pressure, who _____
☐ **Yes** ☐ **No** Cancer, Type, who _____
☐ **Yes** ☐ **No** Lupus, who _____
☐ **Yes** ☐ **No** Arthritis, who _____
☐ **Yes** ☐ **No** Strokes, who _____
☐ **Yes** ☐ **No** Other_____

Your Social History

☐ **Yes** ☐ **No** Do you use tobacco products?
☐ **Yes** ☐ **No** Former Smoker. **What year you stopped?** _____
☐ **Yes** ☐ **No** Current Occasional Smoker
☐ **Yes** ☐ **No** Current Everyday Smoker
_____ ½ pk/day _____ 1 pk/day _____ 1+day

☐ **Yes** ☐ **No** Do you drink alcohol? If yes- How much/often
_____ Occasional _____ 1-2 per day
_____ 3-4 per day _____ 4+ per day
☐ **Yes** ☐ **No** Do you use illegal drug?

Your Primary Care Physician

First name: _____ Last name: _____
Phone ( ) _____ - _____

Address: _____ City: _____ Zip: _____

ROS from: _____/_____/_____ Reviewed. Sig.Reviewing Dr: _____
ROS reviewed from _____/_____/_____ No changes, Yes Changes Initial DR _____
ROS reviewed from _____/_____/_____ No changes, Yes Changes Initial DR _____
ROS reviewed from _____/_____/_____ No changes, Yes Changes Initial DR _____

Office Use: Rev.05/16 99%

SYMPTOMS CHECK LIST Name _____ Date _____ /_____ /_____

YES	NO	
		Do you ever get sleepy when reading or doing near tasks?
		Are you uncomfortable when reading or doing other near tasks?
		Do your eyes feel tired when reading or doing other near tasks?
		Would you like to read faster?
		After reading do you look up and notice that distance vision is momentarily blurred?
		Does your eyes itch / burn / tear / pull or ache? (circle problems you experience)
		Do you experience motion sickness?
		Do you ever have double vision at any visual task?
		Is it an effort to keep your concentration when reading? (Short attention span)
		Does your comprehension decline as reading continues?
		Do you lose your place while reading?
		Do you use your finger or marker to keep your place while reading or copying?
		Do you skip or repeat words or re-read lines?
		Do you experience visual fatigue at the end of the day?
		Do you ever close or cover one eye while reading or looking at distance?
		Do you ever get headaches during or after reading?
		Do you feel a pulling feeling around your eyes when reading or doing close work?
		Do your eyes ever feel sore when reading or doing close work?
		Do you see words move, jump, swim, or appear to float on the page?
		Are you especially sensitive to sunlight or glare?
		Do you **confuse** (please circle) words / letters?
		Do you **reverse** (please circle) words / letters?
		Did you have any difficulties, or did you struggle in school?
		Do you perform better orally than by writing / reading?
		Do you have difficulty with attention? Formal Diagnosis of please circle ADD / ADHD / Suspected Medication : _____

Estimated reading ability? (circle) Poor Fair Average Above-Average Excellent

Do you feel you are performing up to your potential at work? Or School? _____

Y _____ N _____ Do you ever work at a computer (VDT)? If so, how long _____

How long can you read before you notice visual fatigue? _____

How many hours daily do you spend reading or working at near distances? _____

How do your eyes feel after the computer work, reading, or studying? _____

Is there any other information you feel would be helpful / important in your treatment? _____

SPECTACLE LENS HISTORY

Name _____ Date _____ /_____ /_____

Do you currently wear glasses?	☐ Yes	☐ No
If yes, how old is the RX in your current glasses?	_____ Months / years old	☐ Full time use ☐ Part time use ☐ Reading use ☐ Far use
How many hours a day do you wear glasses?	☐ 4 hours ☐ 8 hours ☐ 12 hours ☐ 16 hours	
Glasses owned	☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Sports ☐ Backup Glasses ☐ Other _____	
Hobbies & Needs (check all that apply) *We recommend FDA Approved Safety Glasses for children and sports, construction work, and hobbies such as woodworking.*	☐ Computer ☐ Music ☐ Skiing ☐ Basketball ☐ Soccer ☐ Night Driving ☐ Golf ☐ Racquetball ☐ Hockey ☐ Other: ☐ Photography ☐ Fishing ☐ Tennis ☐ Volleyball _____	
Do you use a computer?	☐ Yes **Hours _____ / Day** **Days _____ / Week**	☐ No
Do you **have visual difficulty** when driving?	☐ Yes	☐ No
Do you have **problems with night vision?**	☐ Yes	☐ No

CONTACT LENS HISTORY

Do you currently wear **contact lenses**? ☐ Yes ☐ No How many years? Brand? Power Right: Left:

How many **hours/day**?

How many **days/week**? Sleep in contacts **overnight**? How many **nights/week**?

How often do you **replace / dispose** of them?

Have you had any infections related to CL wear?

Which **disinfecting product** do you use to store your lenses? ☐ Various Brands ☐ Peroxide System

Do you experience: ☐ Discomfort wearing CL's ☐ Short CL wearing time ☐ Dry eyes ☐ Allergies to CL solutions ☐ Red eyes with CL's ☐ Poor far/ near vision ☐ Eye itch with CL removal ☐ Contact Lens intolerance

Rate how your lenses feel
Immediately **AFTER** you first put them **IN.** **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent** **Insertion TIME**: _____ **AM**

Rate how your lenses feel
Immediately **BEFORE** you take them **OUT**. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent** **Removal TIME: _____ PM**

Do you use **contact lens rewetting drops**? ☐ Yes ☐ No

Do you have fluctuations in your vision throughout the day, after reading for any length of time or when using the computer? **YES** **NO**

Do you take Antihistamines, Blood Pressure medications, Oral Contraceptives, Antidepressants and/or Cholesterol-Lowering medications?

YES, please specify _____ NO

How may weeks in a year do you travel? _____ WEEKS

If not a contact lens wearer, have you ever worn them in the past? ☐ Yes ☐ No

If yes, **when** did you discontinue using them? **Why** did you stop using them?

I understand there is additional fee for a contact lens evaluation & services

I understand in order to finalize a contact lens prescription, follow-up visits need to be made ***within 30 days of the initial contact lens evaluation and services, lens availability allowing. Additional charges will incur if the visits are missed and extend beyond the 30 days.*** *I understand that the FDA considers contact lenses medical devices and that contact lens prescriptions expire every year. The FDA requires an annual contact lens evaluation, for which a separate fee is charged beyond the routine eye exam. We evaluate prescription and lens design during this process. Patients will incur additional charges for medical exams (red eye, abrasions, GPC, etc.).* I understand that to maintain a successful contact lens wearing experience, I must adhere to ***proper lens care, good personal hygiene, scheduled lens replacements, and an annual eye exam.*** I understand there are ***inherent risks*** wearing *contact lenses, such as eye irritation, infection, possible corneal injury and vision loss, if I EXCEED the wearing schedule prescribed by my optometrist or do not care for my lenses properly.* ***Contact Lens Examination Fees, as with all professional fees, are non-refundable.***

_____ _____ _____

Patient / Guarantor Signature **Print Patient / Guarantor Name** **Date**

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