Newport Eye Physicians

Patient Information

Name (Last, First): _____MI: _____

Phone (Home):_____ (Cell): _____ (Work/Business): _____

Address: _____ City: _____ State: _____ Zip: _____

Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ E-mail: _____

Male: ☐ Female: ☐ D.O.B. _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Responsible Party & Primary Physician Information

Responsible Party: Self ☐ (check if same as above) _____ D.O.B. _____

Relationship to Patient: Self: ☐ Spouse: ☐ Other: _____ SSN: _____

Phone (Home):_____ (Cell): _____ (Work/Business): _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Primary Physician: _____Phone:_____

Emergency Contact

Name of person not living with you: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Referral Source

How did you hear about us?
Other Doctor: _____ Friend/Relative: _____ Website: _____
Insurance Co: _____ Mail: _____Other (please specify): _____

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE TREATED AS CONFIDENTIAL AND IN ACCORDANCE WITH STANDARD MEDICAL GUIDELINES.

I HEREBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO *NEWPORT EYE PHYSICIANS*, AND ANY ASSISTING PHYSICIANS, FOR SERVICES RENDERRED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTIONS, AND REASONABLE ATTORNEY'S FEES. I HEREBY AUTHORIZE *NEWPORT EYE PHYSICIANS* TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS, AND I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Patient's Name: _____

Patient's Signature: _____ Date: _____

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Eye History

1. Any **eye symptoms**? Check all that apply:

☐ Blurred Vision (Near, Far, Computer, All)	☐ Eyelid Crusting	☐ Eye Pain
Flashes of Light	☐ Halos	☐ Discharge
☐ Light Sensitivity	☐ Double Vision	☐ Decreased Vision
☐ Floaters	☐ Eye Itchiness	

2. Do you wear **glasses**? ☐ YES ☐ NO ☐ Readers Only
3. Do you wear **contact lenses**? ☐ YES ☐ NO Brand/Power: _____
4. Do you have **problems reading**? ☐ YES ☐ NO
5. Have you ever had an **eye injury**? ☐ YES ☐ NO Describe: _____
6. Have you ever had **eye surgery**? ☐ YES ☐ NO Describe: _____
7. Are you being treated for any **medical conditions**?

Diabetes:	☐ YES ☐ NO	Heart Disease:	☐ YES ☐ NO	Stroke:	☐ YES ☐ NO
High Blood Pressure:	☐ YES ☐ NO	Arthritis:	☐ YES ☐ NO	Other:	_____

8. Are you currently using any **eye medications**? ☐ YES ☐ NO Describe: _____
9. Do you currently use:

Coumadin:	☐ YES ☐ NO	Aspirin:	☐ YES ☐ NO	Plavix:	☐ YES ☐ NO
Flomax:	☐ YES ☐ NO	Omega 3 (fish oil):	☐ YES ☐ NO	Vitamin E:	☐ YES ☐ NO

10. Please list any other **medication** you are currently taking: _____

_____

11. Any known **allergies**? ☐ YES ☐ NO Please describe: _____
12. Do you have any **family history** of eye problems? Please circle and list family relationship:

Glaucoma Cataract Macular Degeneration Diabetic Eye Disease Retinal Disease

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Patient Name: _____

Patients Signature: _____ **Date:** _____

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Medical/Cosmetic Questionnaire

Please circle if you currently **HAVE** or **HAVE HAD** the following:

EYES: NONE

Corneal Injury/Scars
Corneal Transplant
Eye Hemorrhage
Glaucoma
Macular Degeneration
Retinal Detachment
Tearing/Dry Eyes

OTHERS: NONE

Anemia
Asthma
Arthritis
Bleeding/Blood Clotting
Blood Transfusion
Bone/Joint Disease
Bruise Easily
Cancer
Chemotherapy
Cough
Depression
Diabetes
Eczema
Emphysema (COPD)
Heart Disease/Attack/Bypass
Hepatitis
High Blood Pressure
High Cholesterol
HIV Disease
Infection(s)
Kidney Disease
Liver Disease
Migraine or Other Headaches
Pacemaker
Pneumonia
Psychiatric Care
Radiation Therapy
Rheumatic Fever
Seizure
Stroke (CVA)
Thyroid (Graves) Disease
Tuberculosis
Ulcer(s)
Other / Explain: _____

Please circle if you **HAVE HAD** or **WOULD LIKE TO HAVE** the following:

EYE/FACIAL IMPROVEMENTS

Blepharoplasty	Would Like
Cataract Surgery	Would Like
Drooping Eyelid Repair	Would Like
Eye Fat Pocket Reduction	Would Like
Reduction of Eye "Tearing"	Would Like
BOTOX Treatment(s)	Would Like
JUVÉDERM Treatment(s) (or other fillers)	Would Like
LATISSE Treatment(s)	Would Like
PROVAGE MD Treatment(s)	Would Like

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Notification of Insurance Information Changes

We are committed to providing you with the best possible care. If you have insurance, we are happy to submit your claims for processing. Please submit to our office a copy of your new insurance card to inform us of any changes in your plan. Remember, your notification of any changes in your insurance must be submitted to us **before** service are rendered.

Please be advised that you will be responsible for payment for services if you do not notify us **before** services are rendered, of any changes in your insurance information. This would include changes in your medical group or IPA, health plan, primary physician, referring physician, benefits, and eligibility.

By signing below, I am stating that I have read and understand the above information, and I will bring *Newport Eye Physicians* a copy (of both sides) of my new insurance card when it changes.

Privacy Practices Acknowledgement

By signing below, I am stating that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and to ask any questions about it.

Authorization to Leave Messages

By signing below, I am giving my permission for the staff of *Newport Eye Physicians* to leave messages, either with a live person or on my answering machine, regarding my health care, test results, and/or my appointments at the following phone number(s):

_____

_____

Patient Name: _____

Patients Signature: _____ Date: _____