NEW PATIENT INTAKE FORM

☐ **MR** ☐ **MRS** ☐ **DR** ☐ **MS** ☐ **MISS**

LAST NAME _____ **FIRST NAME** _____ ☐ **M** ☐ **F** **BIRTH DATE** ___/___/__**AGE** ____

ADDRESS _____**UNIT #** _____ **CITY** _____ **STATE** _____ **ZIP** _____

HOME PHONE (___ ___) _____ **CELL PHONE** (___ ___) _____
(USED ONLY FOR APPOINTMENT REMINDERS. CALLS MAY BE LIVE OR PRERECORDED)

EMPLOYER _____ **OCCUPATION** _____ ☐ RETIRED ☐ UNEMPLOYED ☐ STUDENT ☐ F/T ☐ P/T

EMAIL _____ **PREFERRED METHOD OF CONTACT**: ☐ EMAIL ☐ TEXT ☐ PHONE

ARE WE WORKING WITH A VISION PLAN TODAY?

VISION PLAN: ☐ NONE ☐ EYEMED ☐ VSP ☐ DAVIS ☐ SUPERIOR ☐ BLUE VIEW ☐ HUMANA VCP ☐ AETNA VISION ☐ OTHER

VISION PLAN ID # _____ **INSURED NAME** _____ **INSURED DOB** ___/___/___

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN **PRIMARY INSURED SSN** _____

MEDICAL/HEALTH INSURANCE INFORMATION ☐ NO MEDICAL/HEALTH COVERAGE AT THIS TIME

MEDICAL INSURANCE PLAN _____**INSURED ID #**_____ **GROUP #** _____

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN **PRIMARY INSURED SSN** _____

INSURED NAME LAST_____ **FIRST** _____ **INSURED DOB** ___/___/___

INTERVIEW

EYE CONDITIONS: **HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**

☐ **NONE** ☐ CATARACTS ☐MACULAR DEGENERATION ☐ GLAUCOMA ☐ DIABETES ☐ DIABETIC RETINOPATHY ☐ DRY EYE

☐ IRITIS OR UVEITIS ☐ RETINAL DEFECTS OR DEGENERATIONS ☐ AMBLYOPIA/LAZY EYE ☐ RETINAL DETACHMENT/TEAR/HOLE

EYE CONCERNS: **ARE YOU HAVING ANY OF THE FOLLOWING EYE CONCERNS?**

☐ **NONE** ☐ REDNESS ☐ BURNING ☐ ITCHING ☐ TEARING ☐ DISCHARGE ☐ FLOATERS ☐ FLASHES ☐ DRYNESS

VISION CONCERNS: **ARE YOU HAVING ANY OF THE FOLLOWING VISION CONCERNS?**

☐ **NONE** ☐ BLURRED VISION ☐ EYE STRAIN ☐ EYE PAIN ☐ SEVERE SENSITIVITY TO LIGHTS ☐ HEADACHE

☐ POOR NIGHT VISION ☐ BOTHERSOME NIGHT GLARE ☐ DOUBLE VISION ☐ TOTAL LOSS OF VISION

REVIEW OF SYSTEMS: DO **YOU** HAVE ANY OF THE FOLLOWING CONDITIONS?

					OTHER
CONSTITUTIONAL:	☐ NONE	☐ DIZZINESS	☐ FATIGUE	☐ DISORIENTATION	_____
EARS, NOSE, THROAT:	☐ NONE	☐ DRY MOUTH	☐ HEARING LOSS	☐ SINUSITIS	_____
NEUROLOGICAL:	☐ NONE	☐ BELL'S PALSY	☐ MIGRAINES	☐ MULTIPLE SCLEROSIS	_____
PSYCHIATRIC:	☐ NONE	☐ ADHD/ADD	☐ ANXIETY	☐ DEPRESSION	_____
CARDIOVASCULAR:	☐ NONE	☐HIGH BLOOD PRESSURE	☐ HIGH CHOLESTEROL	☐ STROKE	_____
RESPIRATORY:	☐ NONE	☐ ASTHMA	☐ COPD	☐ EMPHYSEMA	_____
GASTROINTESTINAL:	☐ NONE	☐ LIVER DISEASE	☐ CROHN'S DISEASE	☐ IRRITABLE BOWEL	_____
GENITOURINARY:	☐ NONE	☐ STD	☐ UTERINE CANCER	☐ PROSTATE DISORDER	_____
MUSCULOSKELETAL:	☐ NONE	☐ OSTEOPOROSIS	☐ RHEUMATOID ARTHRITIS	☐ ANKYLOSING SPONDYLITIS	_____
INTEGUMENTARY (SKIN):	☐ NONE	☐ ROSACEA	☐ PSORIASIS	☐ MELIGNANT MELANOMA	_____
ENDOCRINE:	☐ NONE	☐ DIABETES TYPE ____	☐ THYROID PROBLEM	☐ KIDNEY DISORDER	_____
HEMATOLOGIC/LYMPH:	☐ NONE	☐ ANEMIA	☐ LEUKEMIA	☐ TEMPORAL ARTERITIS	_____
IMMUNOLOGIC:	☐ NONE	☐ HIV/AIDS	☐ LUPUS	☐ HERPES SIMPLEX/ZOSTER	_____

ARE YOU CURRENTLY PREGNANT OR NURSING/BREASTFEEDING? ☐ PREGNANT ☐ NURSING/BREASTFEEDING ☐ N/A

ARE YOU CURRENTLY TAKING ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER, INCLUDING VITAMINS)? PLEASE LIST.

☐ NONE _____

_____

ARE YOU CURRENTLY USING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? IF SO, PLEASE LIST.

☐ NONE _____

DO YOU HAVE ANY ALLERGIES (INCLUDING TO MEDICATIONS, DYES, ENVIRONMENTAL OR OTHER)? IF SO, PLEASE LIST.

☐ NONE _____

HAVE YOU EVER HAD ANY SURGERIES OR INJURIES TO YOUR EYES? IF SO, PLEASE LIST PROCEDURE/INJURY AND APPROXIMATE DATE.

☐ NONE _____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DRINKS PER DAY? ☐ <1 ☐ 1 ☐ 2 ☐ 3 OR MORE

DO YOU SMOKE? ☐ YES ☐ NO ☐ FORMER SMOKER IF YES, HOW MANY PACKS PER DAY? ☐ <1 ☐ 1 ☐ 2 ☐ 3 OR MORE

FAMILY HISTORY: DOES ANY OF YOUR **IMMEDIATE FAMILY** (I.E. PARENTS, SIBLINGS) HAVE ANY OF THESE CONDITIONS? PLEASE LIST THE IMMEDIATE FAMILY MEMBER.

☐ **NO FAMILY HISTORY OF ANY OF THE FOLLOWING CONDITIONS**

	FAMILY MEMBER		FAMILY MEMBER		FAMILY MEMBER
☐ AUTOIMMUNE	_____	☐ CANCER	_____	☐ DIABETES TYPE ☐ 1 ☐ 2	_____
☐ HIGH BLOOD PRESSURE	_____	☐ HYPERTHYROID	_____	☐ HYPOTHYROID	_____
☐ HEART DISEASE	_____	☐ HIGH CHOLESTEROL	_____	☐ MIGRAINE	_____
☐ LAZY EYE/AMBLYOPIA	_____	☐ DIABETIC RETINOPATHY	_____	☐ CATARACT	_____
☐ MACULAR DEGENERATION	_____	☐ GLAUCOMA	_____	☐ RETINAL DETACHMENT	_____
☐ SICK CELL RETINOPATHY	_____	☐ **OTHER**_____	_____	☐ **OTHER**_____	_____

WOULD YOU LIKE INFORMATION ON LASIK? ☐ YES ☐ NO

ARE YOU PLANNING TO GET CONTACT LENSES TODAY? ☐ YES ☐ NO ☐ INTERESTED ☐ ONLY IF RECOMMENDED

HAVE YOU WORN CONTACTS BEFORE? ☐ PREVIOUSLY WORN CONTACT LENSES ☐ NEW TO CONTACT LENSES ☐ N/A

*CURRENT CONTACT LENS BRAND:*_____ ☐ UNSURE OF BRAND ☐ N/A

CURRENT CONTACT LENS TYPE: ☐ SINGLE VISION ☐ TORIC/ASTIGMATISM ☐ MULTIFOCAL ☐ N/A

CURRENT CONTACT LENS PRESCRIPTION: RT EYE _____ BC: ____ LT EYE _____ BC: ____ ☐ N/A

ARE YOU HAPPY WITH YOUR CURRENT CONTACTS? ☐ YES ☐ NO ☐ N/A

REPLACEMENT: ☐ MONTHLY ☐ DAILY ☐ 2 WEEK ☐ N/A **DO YOU SLEEP IN CONTACT?** ☐ YES ☐ NO ☐ SOMETIMES ☐ N/A

OPTOMAP Digital Imaging

Optomap is a state-of-art digital scanning technology that allows the doctors to view the inside of your eyes without the use of dilation drops and side effects. It enables us to evaluate your retina for problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, hypertension and diabetic retinopathy. Dilation still may be necessary under certain conditions. In most cases, this procedure is not covered by insurance. The scanning is safe for kids, adults, and pregnant women and also gives you the opportunity to see the inside of your own eyes just as the doctor sees it. In order for the doctors to evaluate your eyes thoroughly, **Optomap is required should you refuse dilation**

☐ **I consent to have the OPTOMAP Digital Imaging performed $35 additional fee applies** ☐ **I consent to have my eyes DILATED**

INITIAL _____

AUTHORIZATION AND RELEASE

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to insurance companies and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize the release or discussion of any information including the diagnosis and the records of any treatment or exam to:

_____ (name of spouse, family members, etc.) **INITIAL** _____

HIPAA

It is required by applicable federal and state law to maintain the privacy of your health information. You are provided an opportunity to read our posted "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You can request a copy at any time. Our office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be made aware of the revised notice with your first visit following the policy change. You may refuse to sign this acknowledgment. You also have the right to revoke this acknowledgment except to the extent that we have already initiated action prior to revocation. If you choose to revoke this acknowledgement, you must do so in writing. This acknowledgement must be signed by the patient (or the patient's parent/legal guardian) if the patient is under the age of eighteen.

INITIAL _____

NEXT APPOINTMENT REMINDERS

I authorize Dr Toshiya Arciaga & Associates to contact me with appointment reminders through text, email, phone and appointment reminder cards.

INITIAL _____

I understand that Dr Toshiya Arciaga & Associates is totally independent from LensCrafters. LensCrafters provides a service to Dr Toshiya Arciaga & Associates to use a web-based appointment and recall system which also allows coupons to be mailed or emailed to our patients from LensCrafters with your reminder card. Since Dr Toshiya Arciaga & Associates and LensCrafters use this common service, there will be no duplicate mailings or duplicate calls to remind you of your next appointment.

I allow Dr Toshiya Arciaga & Associates to share my name, address, phone number, email and next appointment date/time with LensCrafters for these services. I understand that the information I authorize the above entity to receive may be re-disclosed and no longer protected by federal privacy regulation. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment; or eligibility for benefits unless allowed by law. I understand that I may inspect or copy the information being disclosed. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. This authorization expires four years from the date of my signature.

INITIAL _____

PATIENT/GUARDIAN SIGNATURE **X** _____