LIFETIME EYECARE® OPTOMETRY, P.A.
A MEMBER OF VISION SOURCE™

New Patient History Form
Thank You!
Chart#_____

Patient Name _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____ Daytime Phone_____

Email _____Marital Status_____ Family Dr._____

If minor, responsible party and their relationship_____

Employer _____ Occupation _____

Do you have any medication allergies?_____

List all medications you are currently taking:_____

_____

What eye surgeries have you had?_____

What other surgeries have you had?_____

When was your last eye examination? _____ Where?_____

List any eye disorders you have: _____

Check all that have affected you recently:

_____Discomfort with your eyes _____Headaches _____Dry Eyes

_____Problems with glare or reflections _____Floaters or flashes of light _____Other Eye Symptoms

_____Distance blurry with current glasses _____Reading blurry with current glasses

Are you interested in information about Contact Lenses? _____YES or _____NO _____MAYBE

Are you interested in information about Laser Eye Surgery? _____YES or _____NO _____MAYBE

Do you anticipate getting new glasses today? _____YES or _____NO _____MAYBE

Do you have in Contact Lenses today? _____YES or _____NO

List any **family members** and their relationship to you that have:

_____Glaucoma _____Macular Degeneration _____Blindness

_____Cataracts _____Crossed or lazy eye _____Other eye disease

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Please mark any of the following conditions which you have had in the past several weeks:

Allergy/IMM: Allergies_____
Cardio: High Blood Pressure_____ Stroke_____ Chest Pains_____
Constitutional: Fever_____ Feel "sick"_____
Endocrine: Diabetes_____ Thyroid disesase_____
Gastro: GI problems or ulcers_____
Genito/Urinary: Kidney/Bladder problems_____
Head: Headaches_____ Ear/Nose/Throat Problems_____
Hema/Lymph: Bleeding problems_____
Musculoskel: Swollen joints_____
Neuro: Dizziness_____
Psych: Psychiatric Problems_____
Resp: Breathing Problems_____

I authorize the release of any medical or other Protected Health Information necessary to process this claim, or provide treatment. I also request payment of government and insurance benefits payable to Lifetime Eyecare Optometry, P.A. I am responsible for the deductible, co-insurance, and all non-covered services. I am responsible for any and all non-covered services related to insufficient or incorrect insurance information provided to Lifetime Eyecare. I acknowledge that I have been afforded the opportunity to review Lifetime Eyecare's Notice of Privacy Practices and have been given a copy if requested.

Signature:_____ Date:_____