NEW PATIENT QUESTIONNAIRE

Full Name: _____ Preferred Phone: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Other Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Gender (circle): ☐ Female ☐ Male

Guardian (if applicable): _____ Occupation: _____

How did you hear about us? _____ If referred, who may we thank? _____

Circle appropriate selection: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of last visit: _____

Please check appropriate answers and fill in blanks:

	No	Yes	Unsure
Constitutional			
Fever, Fatigue Syndrome	☐	☐	☐
Cancer	☐	☐	☐
Ear, Nose, Mouth, Throat			
Dry Throat/Mouth	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Neurological			
Seizures/Epilepsy	☐	☐	☐
CVA/Stroke	☐	☐	☐
Migraines	☐	☐	☐
Tumor	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Psychiatric			
Anxiety/Depression	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Vascular/Cardiovascular			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Bronchitis	☐	☐	☐

	No	Yes	Unsure
Gastrointestinal			
Acid Reflux	☐	☐	☐
Crohn's Disease	☐	☐	☐
Genitourinary			
Pregnant/Nursing	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
Prostate disease	☐	☐	☐
Bones/Joints/Muscles			
Arthritis	☐	☐	☐
Osteoporosis	☐	☐	☐
Muscle/Joint Pain	☐	☐	☐
Integumentary			
Shingles/Herpes Zoster	☐	☐	☐
Cold Sores/Herpes Simplex	☐	☐	☐
Rosacea	☐	☐	☐
Endocrine			
Type 1 Diabetes	☐	☐	☐
Type 2 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Lymphatic/Hematologic			
High Cholesterol	☐	☐	☐
Anemia	☐	☐	☐
Hepatitis	☐	☐	☐
Allergic/Immunologic			
Environmental Allergies	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐

If you have a condition not listed, please explain and **LIST ANY MEDICATIONS** you are taking (include oral contraceptives, aspirin, over-the-counter medication, vitamins, & home remedies):

_____

_____

_____

Do you have any allergies to medication? □ No □ Yes If yes, explain _____

_____

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	☐	☐	☐	Dryness	☐	☐	☐
Blurred Vision	☐	☐	☐	Mucous Discharge	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Redness	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐
Double Vision	☐	☐	☐	Itching	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	Burning	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Excess Tearing/Watering	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	Glaucoma	☐	☐	☐
Retinal Disease	☐	☐	☐	Cataract	☐	☐	☐
Eye Surgery (LASIK, cataract)	☐	☐	☐	Lazy Eye	☐	☐	☐
Eye Injury	☐	☐	☐	Crossed Eyes	☐	☐	☐

If you answered YES to any of the above, or have a condition not listed, please explain and **LIST ANY EYE DROPS**:

_____

_____

_____

Family History

Please note any family history (parents, grandparents, siblings, children…living or deceased) for the following conditions:

Medical Condition	No	Yes	Unsure	Relationship
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Heart Attack	☐	☐	☐	_____
Stroke	☐	☐	☐	_____

Ocular Condition	No	Yes	Unsure	Relationship
Cataract	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Amblyopia	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____

Social History – This information is kept strictly confidential.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long _____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long _____

Do you use recreational drugs? ☐ No ☐ Yes If yes, type/amount/how long _____

What are your hobbies? _____

_____

Glasses/Contact Lens History

Do you wear glasses? ☐ No ☐ Yes Are they for: ☐ Full time ☐ Reading ☐ Computer ☐ Driving

Do you wear contact lenses? ☐ No ☐ Yes Are they comfortable? ☐ No ☐ Yes

Type of contact lenses: ☐ Soft ☐ Rigid ☐ Extended Wear ☐ Other How often do you dispose of them? _____

Brand of contact lenses_____ How many hours a day do you usually wear them? _____

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAYMENTS

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or Clarity Eye Care.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Clarity Eye Care.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that I am also required to make payment for at least 50% of materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Clarity Eye Care or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

AGREEMENT

_____	_____	_____
Date	Guarantor/Patient Signature	Print Name