# Welcome to Princeton Family Eye Care

Thank you for choosing our office! In order to better serve you, we need the following information. Please print. All information is confidential.

## Patient Information

Patient Name_______________________________________________ Home (____) ____________________
First MI Last
Address__________________________________________________ Work(____)______________________

City______________________ State/Prov._________ Zip___________ Cell (____) _____________________

What number do you prefer we contact you on? Home/ Work/ Cell

What is you cell phone carrier (for future text appointment reminders) __________________________

E-mail Address____________________________________ Marital Status _________________________

Date of Birth_____/______/_____ Age________ Gender ___M___F

Social Security No. ________________________ Driver's Licenses No.______________________________

Primary Language ________________________ Race______________________

Any special needs such as: ____ wheelchair___ hearing impaired ___translator ___ other _______________

Occupation________________________________ Employer________________________________________

Emergency Contact ______________________Relationship ___________________ Phone ________________

What is the state in which you were born? ______________ Mother's Maiden name____________________

How did you hear about our office?
___ our web site ___ insurance list ___ yellow pages___ billboard ___ referred by _____________________

## Insurance

**Vision Insurance** ____ No ____ Yes If yes, name of vision insurance ___________________________
Subscriber Name __________________________ Subscriber Date of Birth ___________________________
Subscriber ID # ____________________________ Subscriber Group # _______________________________

**Medical Insurance** ____ No ____ Yes If yes, name of medical insurance ___________________________
Subscriber Name __________________________ Subscriber Date of Birth ___________________________
Subscriber ID # ____________________________ Subscriber Group # _______________________________

If not covered by insurance who is the responsible party? _________________________________________
Address __________________________________________ Phone __________________________________

Do you participate in a flex spending account? ___ Yes ___ No

# Patient Health History

Name of Primary Care Physician______________________________________ Phone ____________________
Name of Optometrist / Ophthalmologist___________________________________ Last eye exam ___/___/____

**Are you allergic to any medication**? ___ No ___ Yes
If yes, please list___________________________________________________________________________

What is the main reason for your visit today/ complaints? ____________________________________________
_______________________________________________________________________________________________

Do you wear glasses _________ contacts ______ sunglasses ________
Brand name of contacts______________________________________________________________________

Type of Contacts ___ Soft ___ Rigid __ Other ___
Do you sleep in contacts? ___Yes ___No ___Sometimes
How often so you change contacts? daily weekly bi- weekly monthly yearly other__________
What brand of solution do you use on contacts? _____________________________________

Average time spent on computer per day? ___________

## Eye History

- ☐ Headaches
- ☐ Glare/Light Sensitivity
- ☐ Tired Eyes
- ☐ Eye Infection
- ☐ Crossed Eyes
- ☐ Flashing/ Floaters or Spots
- ☐ Macular Degeneration
- ☐ Color Blindness
- ☐ Excess Tearing/Watering
- ☐ Blurred Vision Near
- ☐ Blurred Vision Distance
- ☐ Distorted Vision (halos)
- ☐ Foreign Body Sensation
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Redness
- ☐ Itching
- ☐ Dryness
- ☐ Burning
- ☐ Loss of Vision
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Amblyopia (lazy eye)
- ☐ Eye Pain or Soreness
- ☐ Fluctuating Vision
- ☐ Double Vision
- ☐ Sandy or Gritty Feeling
- ☐ Mucous Discharge
- ☐ Cataracts
- ☐ Other_____________
- ☐ Other _____________

## Health History

Constitutional
- ☐ Developmental delay
- ☐ Weight loss/Weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other_________________

Genitourinary
- ☐ Urinary tract infection
- ☐ Kidney ailments
- ☐ STD: Herpes, Chlamydia, HIV
- ☐ Other____________________

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Muscular dystrophy
- ☐ Other____________________

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other____________________

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other____________________

Neurological
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Other____________________

Psychiatric
- ☐ Depression
- ☐ Panic Disorder
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Other_____________________

Vascular/ Cardiovascular
- ☐ High / Low Blood Pressure
- ☐ Stroke/Heart Problems
- ☐ Other____________________

Endocrine
- ☐ Type 1 /Type 2 Diabetic
- ☐ Thyroid Low / High
- ☐ Other_____________________

Gastrointestinal
- ☐ Ulcer
- ☐ Colitis
- ☐ Digestive
- ☐ Other____________________

Blood/ Lymphatic
- ☐ Anemia
- ☐ Leukemia
- ☐ Other_____________________

Immunologic
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Other_____________________

Ear, Nose, Mouth, & Throat
- ☐ Upper respiratory infection
- ☐ Sinus
- ☐ Other_____________________

Cancer

_____________________________
_____________________________

# MEDICATIONS

**Please list current medications, over the counter medications (this includes eye drops, vitamins) you are presently taking.**

| Name of Medication | Dosage | Purpose | Date Started |
|---|---|---|---|
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## Social History

Do you use tobacco products ___ No ___ Yes If yes, type/amount/ how long? ________________________________
Do you drink alcohol? ___ No ___ Yes If yes, type/ amount/how long? ________________________________
Do you use illegal drugs? ___ No ___ Yes If yes, type/ amount/how long? ________________________________
Have you ever been exposed to or infected with: ____ Gonorrhea ____ Syphilis ____ HIV ____ Hepatitis ____ None

## Family History

Is there any family medical history of any of the following? ___ Yes (**If yes, please list relationship to you**) ___No
___ Blindness________________________________________ ___ Cataracts________________________________________
___ Glaucoma ________________________________________ ___ Cancer ________________________________________
___ Macular Degeneration___________________________ ___ Heart Dieses ____________________________________
___ Retinal Detachment ____________________________ ___ Diabetes ________________________________________
___ Corneal Problems ______________________________ ___ Lazy Eye ________________________________________

*I certify above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Princeton Family Eye Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Princeton Family Eye Care insurance benefits otherwise payable to me. I understand that my eye care 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.*

**X** ______________________________________________ _____/_____/_______
SIGNATURE OF PATIENT (Or parent if a minor) Date

**Financial Responsibility Policy for**
**Princeton Family Eye Care**

This document is provided to you so that you will understand both your responsibility as the patient, and our responsibility as the provider in regards to your insurance coverage.

We accept assignment to many insurance companies, which means, we accept a negotiated rate as a provider. As a courtesy to our patients, we do file the initial insurance claims for those companies for which we have agreed to accept assignment.

All insurance information must be presented at the time of your examination. We cannot accept any changes to this information past the date of service. After that time, we can provide any information you need so that you can file the claim on your own for reimbursement.

Some health plans require that we inform you in advance that they may deny payment for "services not covered", "services not deemed by the health plan to be reasonable and customary or medically necessary", "services not covered for this type of provider", "diagnosis not appropriate for this type of procedure" and "procedure has been deemed to be experimental". Princeton Family Eye Care, renders only services that, in their professional judgment, are necessary to provide quality health care for you.

In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement. Agreement: I have been notified by Princeton Family Eye Care that payment may be denied for the reasons above, or that have been specifically requested by me, the patient.

**If payment is denied, I agree to be personally and fully responsible for payment within six months.**
**Signature**_______________________________________ **Date**_____________________

**Your Health Plan Coverage**

Princeton Family Eye Care is committed to providing you with the best possible care and helping you to receive maximum benefits under your health plan. In order to achieve these goals, we need your assistance.
1. It is your responsibility to know if a referral is necessary for your visit.
2. Co-payments are due at the time of the visit. We are considered "Specialty Co-payments".
3. A valid, current insurance card must be presented at each office visit.
4. If the service is not a covered benefit, or if your health plans tells us you are not covered, **payment in full for all services rendered are due on date of service.** If your insurance subsequently makes payment, any over payments will be refunded to you.

**Regarding Your Health Plan**
1. Your insurance is a contract **between you, your employer and the insurance company.** We are not party to that contract. While we may have an agreement with many of the health plans to provide services, **any questions regarding coverage must be resolved by you with the insurance company.**
2. **Not all services are a covered benefit in all contracts.** Some health plans select certain services that they will not cover.

**By signing below, I acknowledge that I have read this information and understand completely.**
**Signature**________________________________________ **Date**______________________

Authorization Form for Princeton Family Eye Care

Name ___________________________________________

DOB: ____________________ Social Security # ____________________

Address:__________________________________________________________________

**You are not obligated to sign any authorization below. You may revoke your authorization at any time. If you wish to do so, you must contact our office first.**

Please list the family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis.

Name ___________________________________________ Relationship _______________________________

Name ___________________________________________ Relationship _______________________________

I authorize Princeton Family Eye Care office to schedule appointments with other physicians when needed. I understand that my name, date of birth, address, phone numbers, insurance information and diagnosis may be released when scheduling such appointments. I also understand no appointments will be made without my knowledge or consent.

_________ Agree _________ Disagree

I understand that if any prescriptions are prescribed to me, the prescription may need to be phoned, faxed or mailed to the pharmacy. Therefore, my name, date of birth and allergies will be released to the pharmacy of my choice to use.

_________ Agree _________ Disagree

_____________________________________ _____________________

Signature Date

_____________________________________ _____________________

Witness Signature Date