INNOVATIVE EYECARE

For returning patients: I overlooked my information and verify that nothing has changed date:_____ Ints: ____

Date:_____/_____/_____

Name (Last, First, M.): _____

Nickname: _____

Date of Birth: _____/_____/_____ **Gender**: **F M**

***Parent or Guardian's Name** (First & Last): _____

Home Address:

_____

City: _____ **State**: _____ **Zip**: _____

Mailing Address (if different): _____

City: _____ **State**: _____ **Zip**:_____

Home#: _(_____)_____-_____

Cell#: _(_____)_____-_____

Can we text you for reminders & order pick ups? Y N

Email: _____

Patient Medical History

Blurred Near	Y N	Dry eyes	Y N	Autoimmune	Y N
Blurred Distance	Y N	Watering	Y N	Diabetes	Y N
Glare	Y N	Itching/ burning	Y N	Thyroid	Y N
Headaches	Y N	Chronic eyelid infections	Y N	Glaucoma	Y N
Flashes of light	Y N	Migraines	Y N	Macular Degen.	Y N
Loss of side vision	Y N	Seasonal allergies	Y N	Cataracts	Y N
Loss of center vision	Y N	Bumps/Styes	Y N	High Blood Press.	Y N
Floaters in vision	Y N	Eye discharge	Y N	High Cholesterol	Y N

Primary Care Physician Y N If yes, Name/Office: _____

Any known allergies to medications Y N If yes, please list them below:

_____

List any current medications:

_____

_____

(Continue on back)

Family Medical History *(if known)*

Blindness	Y N	Retinal Detachment	Y N	Thyroid	Y N	Cataracts	Y N
High Blood Pressure	Y N	Diabetes	Y N	Glaucoma	Y N		
Autoimmune	Y N	Cancer	Y N	Cholesterol	Y N		

Personal Eye History

What is the reason for your visit today? _____

When was your last eye exam done? _____

Have you had any eye surgeries? If so, for what?

_____

Do you wear glasses? Y N Sunglasses? Y N If yes, did you bring them today? Y N

Do you wear contact lenses? Y N

If yes, what **brand** of contacts do you wear? _____

Insurance Information

Who is the primary member on the insurance?

(Full Name): _____

Date of Birth: _____/_____/_____ Relation to patient: _____

Last 4 numbers of SS# : __ __ __ __ Employer: _____

For Wellness Visits Only:

Vision Insurance Name: _____

Vision Insurance ID# (if available) _____

Vision Insurance PH# (if available) _____

For Medical Visits Only:

Medical Insurance Name: _____

Medical Insurance ID# _____

Medical Insurance PH# (if available) _____

PLEASE READ

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Innovative Eyecare. It is my sole responsibility to know my insurance benefits.

As a courtesy only, Innovative Eyecare may call to verify benefits through the insurance company, this however, is not a guarantee of benefits and only when a claim is received will benefits be determined.

INNOVATIVE EYECARE

10233 S. Parker Rd, Unit 101
Parker, CO 80134
303-840-4949

210 Elizabeth St., Ste.#B
Elizabeth, CO 80107
720-668-8194

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

Date of Birth: _____/_____/_____

I have received and understand this practice's notice of privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its notice of privacy practices and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised notice of privacy practices upon request.

Signature: _____

Date Signed: _____/_____/_____

*Name & relationship to patient *(if signed by a responsible representative of patient)*:

_____

** If you wish to have a copy of our Privacy Practices for your own records, please request for one at the front desk or go to our website; www.InnovativeEyecareParker.com **