INNOVATIVE EYECARE

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

Date:_____

Name: (last, first, m): _____

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

Nickname:_____

*Parent/ Guardian Name (first last): _____

Address: _____ _____

City: _____ State: _____ Zip: _____

Cell#: _(_____)_____-_____ (other)_____:

_(_____)_____-_____

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 at night	Y N	Itching/ burning	Y N	Thyroid	Y N
Headaches	Y N	Chronic eye/lid 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
Double vision	Y N	Eye Pain	Y N	Cancer	Y N

Primary Care Physician: _____ PH: _____

Any known allergies to medications: Y N

List any if applicable:

_____

List any current medications:

_____

_____

_____

____

Family Medical History

Blindness	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
Macular Degen.	Y N	Heart Disease	Y N	Retinal	Y N

Personal Eye History

What is the reason for you visit today? _____

When was your last eye exam done, and

where?_____

Have you had any eye surgeries? If so, Why? When? Where?

_____

_____

Do you wear glasses? Y N Sunglasses? Y N Did you bring them today? Y N

Do you wear contact lenses? Y N Do you know what brand?

_____

Insurance Information

Who is the primary member on the insurance?

(Full Name): _____

Date of Birth: _____ Relation to patient: _____

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

Medical Insurance Name: _____

Medical Insurance ID# _____

Medical Insurance PH# _____

Vision Insurance Name: _____

Vision Insurance ID# _____

Vision Insurance PH# _____

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.

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

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 personal representative of patient):

_____