Welcome to our office! We're happy to have you as our patient.
To provide you with the best possible care, please complete the form below.
Please Print Clearly

Date : ______________________

Name : ____ Nickname : ______________
Last, First, Middle Initial

Date of Birth (M/D/Y) : __________________ Sex : **M F** Marital Status : ______________________

Address : __________________________ City/State : ____________________ Zip : ____________

____

Cell : ( ) -
Home : ( ) -
Work : ( ) - Ext#: ______
Email : __________________________

What is your prefered method of contact?
Cell Home Work
For notifications/reminders do you prefer:
Call Text Email

How did you hear about us? : ____

Personal Medical History

DO YOU CURRENTLY HAVE OR EVER HAD ANY ISSUES IN THE FOLLOWING AREAS?

Blurred Near Vision	Y N	Dryness	Y N	Autoimmune	Y N
Blurred Distance Vision	Y N	Excess tearing/watering	Y N	Diabetes	Y N
Glare at night	Y N	Itching	Y N	Thyroid	Y N
Headaches	Y N	Chronic eye/lid infectior	Y N	Glaucoma	Y N
Flashes of Light	Y N	Migraines	Y N	Macular Degen.	Y N
Eye Injuries	Y N	Seasonal Allergies	Y N	Cataracts	Y N
Loss of side vision	Y N	Bumps/Styes	Y N	High Blood Pressure	Y N
Loss of central vision	Y N	Mucous Discharge	Y N	High Cholesterol	Y N
Floaters in vision	Y N	Eye Pain/Soreness	Y N	Cancer	Y N
Double vision	Y N	Burning	Y N	Rosacea	Y N

- **Women,** are you pregnant? Y N - Are you currently nursing? Y N

Name of your Primary Care Physician/ Medical Doctor : ______________________________

Do you take any prescription or non-prescription medicines regularly? Y N (if yes, list them below)

____

Do you have allergies to any MEDICATIONS? ______________________________

Family Medical History

Blindness	Y N	Heart Disease	Y N	Diabetes	Y N
Cataracts	Y N	Hereditary Disease	Y N	Cancer	Y N
Glaucoma	Y N	High Blood Pressure	Y N	Retinal	Y N
Lazy Eye/Eye turn	Y N	Autoimmune	Y N	☐ Adopted- history not known	
Macular Degen.	Y N	Thyroid Disease	Y N	☐ No Known Family History	

Any Other(s) : ____

____

OPTOMAP RETINAL EXAM

The Optomap provides your doctor with a view of your retina which helps your doctor to evaluate your visual health. This scan can confirm a healthy eye or detect the presence of cararacts or glaucoma. This can also monitor your eye health if you have diabetes, high blood pressure or other medical problems. The Optomap Exam is fast, easy, comfortable and **WILL NOT** leave you with blurry vision for up to 3-5hrs like a Dialated Exam. It allows the opportunity for you and your doctor to view and discuss the images of your eye together at the time of your exam. The doctor strongly believes the Optomap Exam to be an essential part of your comprehensive eye exam. However, most vision/health plans **DO NOT** cover the Optomap Retinal Exam which means you may be responsible for the addition fee of $35.

(Initial your choice)

__________ Yes, I want to do the Optomap Exam and I agree to pay the additional $35 if it is not covered by my Ins.

__________ No, I understand the above and choose not to have the Optomap Exam

OR

__________ I want a Dialated Exam instead, I am aware that I will be light sensitive with blurry vision up to 3-5 hrs.

____

Personal Eye History

What is your reason for today's visit : ______________________________

When was the approximate date of your last exam : ______________________________

Eye Surgeries? : ☐ None ☐ Lasik/PRK ☐ RK ☐ Cataract ☐ Retina ☐ Crossed Eyes ☐ Other __________________

Do you wear **GLASSES?** Y N **If yes**, did you bring them today? Y N

When do you wear your glasses?

☐ Full Time ☐ Reading Only ☐ Distance/Driving Only ☐ Computer Use ☐ While not wearing contact lenses

Describe your Computer use

☐ Extensive (5+ hrs./day) ☐ Moderate (2-4hrs./day) ☐ Low (2hr/day or less) ☐ Rarely

Do you currently wear **CONTACT LENSES?** Y N

-What Brand are your contacts? _________________________

-How many days/week do you wear your contacts? ________

-How often do you replace your lenses with new? __________

-What solution do you use? _______________________

-How many hrs/day do you wear your contacts? _______

-Do you sleep in your contacts? Y N

Vision Insurance Information

Vision Plan Name: ______________________________ Vision ID or SS#: ___________________________________

Member Full Name: _______________________________________ Member DOB: _______________________

Patient Full Name: ____ Patient DOB: ________________________

Relationship to member : ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________

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 by the insurance company will benefits be determined. I understand that as a courtesty my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. Innovative Eyecare will bill the patient's primary insurance company a total of two times before the total balance incurred becomes the patient's responsibility. Innovative Eyecare will give the patient a complete statement showing the amount due and how it was resolved so that it can, in turn, be delivered to the primary insurance company.

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

Notice of Privacy Practices Acknowledgement

Patient Name : ____

Date of Birth : ____________________________

I have received and understand this practice's Notice of Privacy Practices written in plain language. The
I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and

Signature : ____

Date : ________________________

Relationship to patient (if signed by a personal representative of patient) :
____