PATIENT INFORMATION SHEET
Please fill out all pages. (Please Print)

Insight EYECARE

Patient Name: Nickname: DOB: Gender: M / F

Address: City: State: Zip:

Cell Phone: Home Phone:

SSN: Email Address:

Occupation: Employed by:

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name:

Race: ☐ White ☐ Hispanic ☐ Asian ☐ African American ☐ American Indian ☐ Other: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Communication Preference: ☐ Phone ☐ Texting ☐ Email May we text for apt reminders? ☐ Yes ☐ No

Parent/Guardian Name (if applicable): Parent/Guardian DOB:

Emergency Contact: Emergency Phone Number:

Medical Insurance: Please provide us with a copy of your card(s) to keep on file.

Vision Plan: Policy Holder's Name: DOB:

Medicare and Other Medical Insurances

I understand that Insight Eyecare may bill my medical insurance if my exam is not a routine vision exam. I understand that Insight Eyecare is contracted to follow my insurance's billing rules. That may include charging a copay for each visit and that the entire balance of the visit may get applied towards my deductible (which the patient is responsible for) if my insurance plan deems proper.

HIPAA

I agree to and understand that this clinic complies with all requirements of HIPAA, my rights to my records and privacy. I understand that there are full copies of the HIPAA statement available at the front desk and waiting room.
I agree to and understand the policy summaries. I understand that full length copies are available and are posted.

Signed Patient (or Parent/Guardian):_____Date:_____

If you would like to authorize us to share your records with anyone such as family or a guardian, list their names below:
☐ Spouse ☐ My Children ☐ My Parents ☐ Other: _____

For new patients, how did you hear about us?
☐ Drive by ☐ Google ☐ Our website ☐ Vision Plan ☐ Referred by: _____

MEDICAL HISTORY QUESTIONNAIRE
This questionnaire is designed to speed up your visit today. All questions are either pertinent to the health of your eyes or are legally required. Thank you for your cooperation!

Primary Care Physician: _____

Medical History

Eyes	Yes	No		Yes	No
Recent Blurred Vision	□	□	Sudden Changes to Vision	□	□
Itching, Burning, or Discharge	□	□	Glare, Light Sensitivity, or Halos	□	□
Eye Pain or Soreness	□	□	Dry Eye or Fluctuating Vision	□	□
Eye Injury or Other Eye Disease	□	□	History of Crossed or Lazy Eye	□	□
Suffered 2 or more Concussions?	□	□	Difficulties in School	□	□
Have you ever had prism in your glasses?				□	□
Have you ever been suspected of having or have glaucoma?				□	□
Headaches or Blurry Vision at the end of the day?				□	□

Current or Previous Medical Problems					
Ears, Nose, Mouth, Throat	□	□	Cardiovascular (Heart, Blood)	□	□
Respiratory (Lungs, Breathing)	□	□	Digestive (Stomach, Intestines)	□	□
Genitourinary (Kidney, Bladder)	□	□	Musculoskeletal (Muscles, Joints)	□	□
Integument (Skin, Breast)	□	□	Neurological	□	□
Psychiatric	□	□	Endocrine (Hormones, Glands)	□	□
Immune Syst. (Blood, Arthritis)	□	□	Seasonal Allergies	□	□
Cancer /Tumors	□	□	Diabetes (Anytime or Borderline)	□	□
High Blood Pressure	□	□	Sleep Apnea	□	□
Do you have High Cholesterol	□	□	Are you Pregnant?	□	□

Any other Medical Problems or Conditions: _____

_____

Please List any Eye drops Recently Used:_____

List any Surgical Procedures to the Eyes or Body: _____

_____

List any Medications that you are Currently Using or Provide a Preprinted List: _____

_____

_____

Please List all Allergies to Medications: None □ _____

OCULAR Family History	Yes	No		Yes	No	
Blindness	□	□	Glaucoma	□	□	If yes, what family member:
Macular Degeneration	□	□	Retinal Detachment	□	□	_____

MEDICAL Family History (siblings, parents, or grandparents)

Diabetes	□	□	Arthritis, Lupus, etc.	□	□
Cancer	□	□	If yes, what family member:_____		

Social- Government required questions:

Do you drink alcohol?	□ Never	□ Less than 10 drinks/week	□ Greater than 10 drinks/week
Do you use tobacco?	□ Yes □ No	How often per day (tobacco)? _____	

Preferred Pharmacy: _____ □ None

OCULAR	**Yes**	**No**		**Yes**	**No**
Have you ever worn glasses before?	☐	☐	Do you like wearing them?	☐	☐
How old are your most recent glasses?	_____years		Are you interested Lasik info?	☐	☐
Are you interested in new glasses if helpful?	☐	☐			

Contacts					
Are you interested in wearing contacts?	☐	☐	Have you worn contacts before?	☐	☐

Contact lenses require additional examination and follow ups. A contact lens examination fee is required which covers the additional time and any follow up visits to fit the contacts. Our contact lens fittings start at $60 and depend on the difficulty of the fit. Please refer to front desk for any pricing questions.

Are you interested in your main glasses transitioning into sunglasses? ☐ Yes ☐ No

Do you get glare while driving with your glasses or contacts? ☐ Yes ☐ No ☐ Only at night

How many hours a day do you use a Computer/Tablet/Reader/Cell Phone: ☐ Less than 2 ☐ 2 – 8 ☐ More than 8

Do you look at multiple computer screens at one time? ☐ Yes ☐ No

After using a computer or electronic device while wearing glasses or contacts, do your eyes seem tired? ☐ Yes ☐ No

Digital Eye Scan

"I want all of my patients to have our disease scan, including kids. It can find diseases earlier than a photo or my microscope. It allows us to detect disease years before vision is affected, meaning we can prevent vision loss before it starts." Dr. Tate.

- A lasting record of the health of the eyes today to refer back to.
- A digital image of the inside of the eye and a safe scan of the macula and optic nerve.
- Your doctor will review and explain the results with you.

Without the eye disease scan, you may be limiting the ability to determine the health of the eye, unless you are scheduled to see Dr. Tate for a Dilated Medical exam. We use mild dilation on all complete, yearly exams.

This is highly recommended if you have glaucoma or macular degeneration in your family. Unless you have already been diagnosed with an eye disease, insurance does not pay for advanced tests like the disease scan. The additional fee is $25. This is not paid by any insurance.

☐ Yes, I would like the scan ☐ No, I do not want my eyes scanned

By signing below, I confirm that these records are full and accurate to the best of my knowledge.

Signed Patient (or Parent/Guardian): _____ Date: _____