NEW MEXICO EYECARE ASSOCIATES, INC

**P A T I E N T I N F O R M A T I O N**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | | | **Date of Birth** |  | |
| **Address** |  | | | **SSN** |  | |
| **City** |  | | **State** |  | **Zip** |  |
| **Home Phone** |  | | **Cell Phone** | |  | |
| **Work Phone** |  | | **Email** | |  | |
| **Gender** |  |  | **Preferred Language** | |  | |
| **Race** |  | | **Ethnicity** | |  | |
| **Employer** |  | | **\*How did you hear about us:** | |  | |
| **Primary Physician** |  | | **Physician Phone #** | |  | |
| **Referring Physician** |  | | **Physician Phone #** | |  | |

**V I S I O N I N S U R A N C E I N F O R M A T I O N**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Insurance Co.** |  | | **Insurance Phone #** | |  |
| **Insurance ID#** |  | | **Group #** | |  |
| **Insured’s Name** |  | | **Insured’s SSN #** | |  |
| **Insured’s D.O.B.** |  | **Relationship to Patient** | | **(check one) Self\_\_\_ Spouse\_\_\_Child\_\_\_Other\_\_\_** | |

**Vision Plans cover “well vision” exams. Any medical history or diagnosis that can affect the eyes will result in the visit being billed to your medical insurance.**

**P R I M A R Y M E D I C A L I N S U R A N C E I N F O R M A T I O N**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Insurance Co.** |  | | **Insurance Phone #** | |  |
| **Insurance ID#** |  | | **Group #** | |  |
| **Insured’s Name** |  | | **Insured’s SSN #** | |  |
| **Insured’s D.O.B.** |  | **Relationship to Patient** | | **(check one) Self\_\_\_ Spouse\_\_\_Child\_\_\_Other\_\_\_** | |

**S E C O N D A R Y M E D I C A L I N S U R A N C E I N F O R M A T I O N**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Insurance Co.** |  | | **Insurance Phone #** | |  |
| **Insurance ID#** |  | | **Group #** | |  |
| **Insured’s Name** |  | | **Insured’s SSN #** | |  |
| **Insured’s D.O.B.** |  | **Relationship to Patient** | | **(check one) Self\_\_\_ Spouse\_\_\_Child\_\_\_Other\_\_\_** | |

|  |  |
| --- | --- |
| **CONSENT TO TREAT**  **I, the undersigned, hereby consent to treatment including tests, procedures and medications directed by New Mexico Eyecare Asscoiate providers.** | **NOTICE OF PRIVACY PRACTICES**  **I, the undersigned, have had an opportunity to review the Notice of Privacy Practices and HPPA.**  **\_\_\_\_Patient was unable to sign.** |

**PAYMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION**

**I, the undersigned, authorize payment of benefits as determined by the Insurance Company directly to New Mexico Eyecare Associates. I authorize New Mexico Eyecare Associates, Inc. to release any information requested, including medical information, to any insurance company, employer, third party payer, third party administrator for purposed of processing my claims.**

**RESPONSIBLE PARTY STATEMENT**

**Full payment for professional services and eyewear purchases are due at the time services are rendered. We accept cash, checks, all major credit cards, and Care Credit. If you are unable or unprepared to pay your co-pays or professional fees that are not covered by insurance at the time of the service, we will gladly reschedule your appointment. As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance, and/or deductibles and non-covered services in accordance with the terms and conditions of my vision or health insurance policy.**

**Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(print name)**

**Patient/Responsible Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSONAL HEALTH HISTORY** (check if yes)

**Eyes (current symptoms & history)**

**☐ none**

**☐ dry eyes**

**☐ eye pain**

**☐ eyelid swelling**

**☐ floaters**

**☐ flashes**

**☐itching eyes**

**☐light sensitivity**

**☐ cataract**

**☐ glaucoma**

**☐ macular degeneration**

**☐ surgery**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ eye drops or eye medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergic/Immunologic**

**☐ none**

**☐ drug allergy**

**☐hay fever/seasonal**

**☐ rheumatoid arthritis**

**☐ lupus**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardiovascular**

**☐ none**

**☐ heart disease**

**☐ hypertension**

**☐ stroke**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Constitutional**

**☐ none**

**☐ fatigue**

**☐ migraines**

**☐ weight loss/gain**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ears, Nose, Throat**

**☐ none**

**☐ hearing problems**

**☐ sinus problems**

**Ears, Nose, Throat (cont.)**

**☐TMJ disorder**

**☐ upper resp. infection**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endocrine**

**☐ none**

**☐ diabetes**

**☐ high/low blood sugar**

**☐ thyroid dysfunction**

**☐ hormonal dysfunction**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gastrointestinal**

**☐ none**

**☐ colitis**

**☐ Crohn**'**s**

**☐ ulcer**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Genitourinary**

**☐ none**

**☐ kidney problems**

**☐ renal failure**

**☐ dialysis**

**☐ sexually transmitted disease**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hematologic/Lymphatic**

**☐ none**

**☐ anemia**

**☐ leukemia**

**☐ cancer**

**☐ HIV**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Musculoskeletal**

**☐ none**

**☐ fibromyalgia**

**☐ muscular dystrophy**

**☐ osteoarthritis**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pregnant ☐ yes☐ no**

**Neurological**

**☐ none**

**☐ multiple sclerosis**

**☐ epilepsy**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric**

**☐ none**

**☐ depression**

**☐ bipolar**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Respiratory**

**☐ none**

**☐ cigarette smoker**

**☐ asthma**

**☐ bronchitis**

**☐ emphysema**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Skin/Integumentary**

**☐ none**

**☐ eczema**

**☐ rosacea**

**☐ psoriasis**

**☐ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alcohol use**

**☐ yes**

**☐ no**

**☐ occasional**

**Tobacco use**

**☐ yes**

**☐ no**

**☐ occasional**

**Marijuana use**

**☐ yes**

**☐ no**

**☐ occasional**

**FAMILY HEALTH HISTORY** (check if yes)

**☐ cancer ☐ high blood pressure ☐ diabetes ☐ heart disease ☐ stroke ☐ glaucoma ☐ cataract ☐ macular degeneration ☐ other Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List of medications you currently take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Drug Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Injuries/surgeries to eyes or body (and dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Thank you for filling out this form completely. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_\_\_**