Welcome to NovaEyes

(Please print the answers to all questions. Your information will remain confidential per HIPAA)

❑Mr. ❑Mrs. ❑Miss. ❑Dr. **Sex:** ❑ Male ❑ Female **Marital Status**: ❑ Never Married ❑ Married ❑ Divorced ❑ Widowed

If minor, Parent/Guardian Name: _____

Name: _____ **Date**: _____
First Middle Last

Address: _____ **Apt #**_____ **City** _____ **State** _____ **Zip** _____

Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____

Date of Birth: _____ **Age**: _____ **Occupation**: _____ **Employer/School Grade**: _____

Email Address: _____ **How did you Hear about us?** _____

We take ***Medical Insurance and Vision plans*** *for the* ***EYE EXAM***. [***If available, please hand in cards to scan***]

Primary Insurance Plan: _____ ID# _____ Subscriber is ❑ Self ❑ Spouse ❑ Parent

Secondary Insurance Plan: _____ ID # _____ Subscriber is ❑ Self ❑ Spouse ❑ Parent

Vision Insurance Plan: _____ ID # _____ Subscriber is ❑ Self ❑ Spouse ❑ Parent

Primary Subscriber Name: _____ **Date of Birth**: _____**Primary SSN**: _____

Primary Care Doctor: _____

Personal Eye History

What is the **reason for your visit** today? _____

Have you had **any of the following** problems?

❑Blurred Vision	❑Red Eyes	❑Glare	❑Eye Pain	❑Glaucoma	❑Floater/Flashes
❑Headache	❑Dryness	❑Twitching	❑Gritty Feeling	❑Cataracts	❑Retinal Problem
❑Double Vision	❑Tearing	❑Lazy Eye	❑Light Sensitivity	❑Iritis/Uveitis	❑Macular Degeneration
❑Injury	❑Crossed Eye/Eye Turn		Other: _____		

Any Eye Surgery: ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Glaucoma ❑ Eyelid ❑ Other _____

When was your **Last Exam**? (Approximately) _____ Doctor's Name/ Location: _____

Family Eye History

❑ Macular Degeneration ❑ Glaucoma ❑ Retinal Problems ❑ Crossed Eye ❑ Other _____

Do you wear GLASSES? ❑ Yes ❑ No If YES, do you have them with you TODAY? ❑ Yes ❑ No

When do you wear your **GLASSES?** ❑Full time ❑ Part time ❑ Reading ❑ Distance/Driving ❑ Computer Use ❑ Safety

Hours per day on Computer, Phone or Reading: _____ HRS. Do your eyes Burn or Sting when doing these activities ❑ Yes ❑ No

Do you Wear CONTACTS? ❑ Yes ❑ No Have you EVER worn Contacts before ❑ Yes ❑ No

What Kind: ❑ Disposable ❑ Toric/Astigmatism ❑ Color ❑ Bifocal ❑ Mono ❑ RGP (Hard)

What is the **Brand** and **Power** of your old contacts: _____ Do you **Sleep** in contacts? ❑ Yes ❑ No

How often do you replace your lenses with new lenses? _____ End of day Dryness? ❑Yes ❑ No Blur Vision? ❑ Yes ❑ No

PLEASE TURN OVER AND FILL OUT BACK SIDE

Personal Medical History *Many medical conditions affect the eye and your vision.*

Current medication: _____

Allergies to medication: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____

❑ Check this box **if NO medical condition apply**. Otherwise, please check all that apply in each box.

Constitutional ❑Weight loss ❑Trauma Fever ❑Fatigue ❑Cancer	**Neurological** ❑Multiple Sclerosis ❑Epilepsy ❑Seizures ❑Headaches ❑Migraines	**Gastrointestinal** ❑Acid Reflux ❑Colitis ❑Crohn's Disease ❑Ulcer
Allergic/Immunologic ❑Environmental Allergy ❑Lupus ❑Rheumatoid Arthritis ❑Drug Allergy	**Endocrine** ❑Type 1 Diabetes ❑Thyroid Disorders ❑Type 2 Diabetes ❑Hormonal Dysfunction	**Musculoskeletal** ❑Fibromyalgia ❑Osteoarthritis ❑Muscular Dystrophy
Cardiovascular ❑High Cholesterol ❑Heart Disease ❑Vascular Disease ❑Stroke ❑High Blood Pressure/HTN	**Blood/Lymphatic** ❑Anemia ❑Leukemia ❑Bleeding Disorders	**Integumentary/Skin** ❑Skin Cancer ❑Eczema ❑Rosacea ❑Psoriasis
Genital, Kidney, Bladder ❑Kidney Concerns ❑UTI ❑STD: Herpes,Chlamydia, HIV	**Psychiatric** ❑Depression ❑ Anxiety ❑Insomnia	**Respiratory** ❑Bronchitis ❑Asthma ❑Emphysema ❑COPD
Ears, Nose & Throat ❑Upper Respiratory Tract Infection ❑Sinus	❑ Premature at birth	❑Other_____

Social History

Tabaco Use? ❑ Never ❑ Current Smoker (Everyday) ❑ Current Smoker (Somedays) ❑ Former Smoker

Drink Alcohol? ❑ No ❑ Yes (Occasionally) ❑ Yes (Socially) **Are you Pregnant?** ❑ Yes ❑ No **Breast feeding?** ❑ Yes ❑ No

BMI info: **Height:** _____ft. _____in. **Weight:** _____lbs. **Race/ Ethnicity:** _____

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize NovaEyes/Paul Cho and Associates, PLLC. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to contact NovaEyes/Paul Cho and Associates, PLLC. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signature_____ **Date**_____

HIPAA - Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office.

The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail.

Please refer to this notice any time prior to signing this Consent Form. **Copies are available for your personal record.**

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

Signature _____

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient _____ **Print Name** _____

THANK YOU, PLEASE TURN IN THIS SHEET WITH YOUR MEDICAL & VISION INSURANCE