Accent Eye Care

New Patient Intake Form

Date _____/_____/_____ Referred By_____ Email _____

PATIENT'S NAME ☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr. LAST _____ **FIRST** _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate ___/___/___ Occupation _____ Employer _____

Spouse _____ Cell Phone(____)_____ Home Phone(____)_____ Work Phone(____)_____X_____

Name and SS # of Primary Insured _____ **D.O.B of Primary Insured**_____

Medical Insurance_____ Vision Insurance_____

Parent/Guardian's name(s) if patient is a dependant _____ School & Grade _____

Are you interested in: (Please check all that apply) ☐ Glasses ☐ Contact lenses ☐ Therapeutic/Vision Therapy ?

Special vision requirements (occupation/computer/hobbies/sports)_____

How many hours a day do you use a computer? _____ Do you presently wear glasses? ☐ Yes ☐ No

Do you presently wear contacts? ☐Yes ☐No Have you ever worn contacts? ☐ Yes ☐ No

Please list main reason(s) for today's exam and any topics you wish to discuss (e.g. no-line bifocals, colored contacts, sunglasses, sports glasses, sports vision therapy, refractive surgery etc…)_____

_____

****MEDICAL HISTORY** (needs to be completed for the examination)** Height_____ Weight _____

List any current medications and the reasons for taking them.

Medication	Reason	Medication	Reason

Are you allergic to ANY medications? ☐ Yes ☐ No - Please List _____

Do you suffer from any of the following (please circle: with glasses / contacts if worn / without correction):

	Yes	No		Yes	No		Yes	No
Distance Vision Blurry.....	☐	☐	Double Vision	☐	☐	Seeing Flashes.....	☐	☐
Middle Distance Blur.....	☐	☐	Itchy Eyes.....	☐	☐	Dry/Scratchy/Watery Eyes....	☐	☐
(Dashboard/ Computer)			Pain In or Around Eyes	☐	☐	Problems with Focusing	☐	☐
Near Vision Blur.....	☐	☐	Eye Strain / Fatigue.....	☐	☐	Headaches.....	☐	☐
Burning Sensation	☐	☐	Seeing Spots or Lines....	☐	☐	Glare	☐	☐

Please list any other problems with your eyes or with your correction: _____

Date of last eye exam _____ DR. _____ Dilated at that exam? ☐ Yes ☐ No

Date of last physical exam _____**General Health from last physical ☐ Excellent ☐Good ☐ Fair ☐ Poor**

Primary care physician _____ **Address** _____ **Phone Number** _____

Name of Pharmacy _____ **Address** _____ **Phone Number** _____

Do you or any BLOOD relatives currently suffer from or have a history of:

	Yes	No	Who
High Blood Pressure....	☐	☐	_____
Color Blindness.....	☐	☐	_____
Cataracts.....	☐	☐	_____
Diabetes	☐	☐	_____
Glaucoma.....	☐	☐	_____
Heart Disease.....	☐	☐	_____

	Yes	No	Who
Allergies/Sinus.....	☐	☐	_____
Amblyopia (lazy eye).....	☐	☐	_____
Macular Degeneration.....	☐	☐	_____
Retinal Detachment.....	☐	☐	_____
Eye Injury.....	☐	☐	_____
Keratoconus.....	☐	☐	_____
Endocrine.....	☐	☐	

	Yes	No	Who
Arthritis.....	☐	☐	_____
Gastrointestinal.....	☐	☐	_____
Respiratory.....	☐	☐	_____
Kidney/Bladder.....	☐	☐	_____
Blood/Bleeding.....	☐	☐	_____
Skin Disease (e.g. eczema)...	☐	☐	_____
Mental.....	☐	☐	_____

☐ Significant weight loss/gain/fatigue

Do you smoke? ☐Yes ☐No If yes, how often? ☐Daily ☐Occasionally If no, have you ever smoked? ☐ Yes ☐ No Date you quit? __/__/____

Do you drink alcohol? ☐Yes ☐No If yes, how often? ☐Daily ☐Occasionally

Do you use recreational drugs? ☐Yes ☐No If yes, how often? ☐Daily ☐Occasionally

Please list any other medical problems or surgeries: _____

OVER PLEASE

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PUPIL DILATION

Dilated exams provide the doctor with a more comprehensive view of the retina (back layer of the eye) and are essential in the early detection and prevention of many eye diseases. Dr. Gong strongly recommends dilation. Eye drops are required and your near vision will remain blurred and light sensitive for several hours. When dilated, we advise you to exert caution when driving.

Please indicate if you wish to have the **dilation** test done today:
☐Yes ☐No ☐Reschedule ☐Discuss with doctor

RETINAL PHOTOS

A retinal photo gives Dr. Gong a detailed picture of the back of your eyes. This can help detect conditions such as glaucoma, diabetes, hypertension, and retinal detachment, among many others. These photos will be saved in your file to compare to over the years.

Please indicate if you wish to have **Retinal Photos** done today:
☐Yes ☐No ☐Discuss with doctor

CONTACT LENS INFORMATION (Please skip this box if you do NOT wear contacts)

1. Brand name of contacts _____ (if not known, please check which types):
   Soft……..☐ Disposable……..☐ Bifocal……..☐
   Hard/Gas Permeable…..☐ Monovision…….☐ Colored…….☐
2. How often do you usually replace your lenses? _____
3. What brand of solution do you soak your lenses in? _____

NOTE: All lenses are not suitable for all patients.
We will discuss what's available for your particular prescription, fitting parameters and lifestyle after the completion of your examination.

REFERRAL, PAYMENT AND AUTHORIZATION

I was referred by Dr. _____ Friend (Name)_____ Family (Name) _____

☐Our Website ☐Internet ☐Insurance Company ☐Other_____

Payment is expected in full when services are rendered. Eyeglasses and contact lenses must be paid for in full.
Who is responsible for your bill (those charges not covered by insurance)? ☐Self ☐Other (Name) _____

I authorize this office to release any information to third-party payers for billing purposes. I authorize and request my insurance company to pay my insurance benefits to Accent Eye Care. I acknowledge that I am financially responsible for any services/materials and claims not covered and /or denied by my insurance for myself and my dependents. Returned checks incur a $30 fee. Appointments not cancelled within 24 hours are subject to a $30 fee. Accent Eye Care is not responsible for previously used frames and/or lenses which are being reused or adjusted at my request. Eyeglass lenses and frames are non-returnable and non-refundable medical devices. Eyeglass frames are warranted only for manufacturer's defects one time within one year of purchase; shipping, handling and restocking fees will apply. Prescription accuracy is warranted and must be reported within 60 days from date of exam with a one time redo of lenses purchased here. Unmarked and unopened contact lens boxes may be exchanged within 60 days from date of exam; a restocking fee will apply. Contact lens fittings are non-refundable. I understand that all fees may be subject to change without notice. Any balance owed by you or the guarantor is subject to a 1.5% late fee (18.0% annum) to be assessed monthly until we receive payment in full. If the account is referred to a collection agency there will be a collection fee of up to 30% over the principle assessed and any applicable fees.

Signature: _____ Date: _____