Pitman Family Eyecare New Patient Information

Name: First _____Middle_____ Last_____
Date of Birth_____ email address_____
Soc Security #_____ Marital status (circle) Single, Married, Widowed
Address_____
City _____State _____ Zip Code_____
Home phone_____ cell phone(preferred) _____
Employer_____Occupation _____
As we get the ability, we will try to contact all patients through text or email.
Race: (please circle) Asian, American Indian, African American, White, other
Ethnicity: (please circle) Hispanic, non-Hispanic
General Physician_____phone # _____
Referred by _____
Pharmacy _____phone #_____

Please check any of the following symptoms you may have or have had:

____ blurred vision	____ lazy eye	____dry eyes	____floaters
____eye pain	____eye injury	____double vision	
____headaches	____itchy eyes	____poor night vision	

other, please list _____

Have you or your family members ever had: (please check)

	You	state which family member
cancer	_____	_____
hypertension	_____	_____
diabetes	_____	_____
liver/lung/ kidney disease	_____	_____
thyroid dysfunction	_____	_____
infectious disease	_____	_____
high cholesterol	_____	_____
glaucoma	_____	_____
cataract	_____	_____
macular degeneration	_____	_____
blood disorder	_____	_____
skin disorder	_____	_____
Ear/nose/throat disorder	_____	_____

If not listed above, please list all medical conditions you have or have been treated for:

_____
_____
_____

The main reason for you visit today is:

____ eye exam _____contacts _____medical injury
____ medical (glaucoma, diabetes, macular degenerattion, cataracts)
____ refractive surgery care _____ pre- or post operative care

Please list all the medications you are taking and the dosage: (or provide a list to us)

_____
_____
_____

Please list all allergies including allergies to medications:

_____
_____
Seasonal allergies : yes / no

Please list all surgeries you have had and the approximate year:

_____
_____
_____

Name of Primary insurance company _____
Name of Policy holder_____Ins ID #_____

Name of Secondary Insurance _____
Name of Policy Holder _____Ins ID #_____

Supplemental Eye Plan (VSP, VBA, Eyemed) _____
Name of Policy Holder_____ Ins ID #_____

Please note: All copayments and fees not submitted to insurance are due when rendered. Insurance must be submitted to us before the appointment otherwise you will have to submit the claim to your insurance company with a paid receipt from us.