

Patient Information

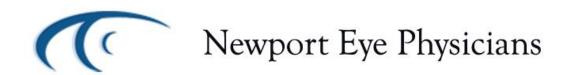
Name (Last, First):				M	[:
Phone (Home):	(Cell):		_(Work/Business):		
Address:	City:	· ·		State:	Zip:
Single: Married: Divor	ced: Widowed:	E-mail: _			
Male: DO.B.		Age:	SSN:	·	
Employer:		O	ccupation:		
Business Address:					
[Responsible Party & Pri	imary Physici	an Information		
Responsible Party: Self [(check	if same as above)			_ D.O.B	
Relationship to Patient: Self:					
Phone (Home):					
Address:					
Employer:					
Primary Physician:				Phone:	· · · · · · · · · · · · · · · · · · ·
	Emerge	ency Contact			
Name of person not living with	you:		Relation	nship:	
Home Phone:	Cell Phone:		Business Pho	ne:	
	Refer	ral Source			
How did you hear about us?					
Other Doctor:	Friend/Rela	ative:		Website: _	
Insurance Co:	Mail:Other (p	lease specify): _			
I CERTIFY THAT TO THE BEST OF MY KNOWILL BE TREATED AS CONFIDENTIAL AN			TELO	T THE INFORMA	ATION PROVIDED
I HEREBY GIVE LIFETIME AUTHORIZATIO PHYSICIANS, FOR SERVICES RENDERRED. INSURANCE. IN THE EVENT OF DEFAULT, EVE PHYSICIANS TO RELEASE ALL INFORM INSURANCE SUBMISSIONS.	I UNDERSTAND THAT I AM FINANCI AGREE TO PAY ALL COSTS OF COL	IALLY RESPONSIBLE LECTIONS, AND REA	FOR ALL CHARGES WHET SONABLE ATTORNEY'S FE	HER OR NOT THEES. I HEREBY A	EY ARE COVERED BY AUTHORIZE <i>NEWPORT</i>
Patient's Name:					
Patient's Signature:			D	ate:	



Newport Eye Physicians

Eye History

Ι.	Any eye symptoms? Check all that apply:				
	Blurred Vision (Near, Far, Computer, All)	Eyelid Crusting		Eye Pain	
	Flashes of Light	Halos		Discharge	
	Light Sensitivity	Double Vision		Decreased Vis	sion
	Floaters	Eye Itchiness			
2.	Do you wear glasses ? YES	☐ NO	Readers Only	y	
3.	Do you wear contact lenses ? YES	□ NO	Brand/Power:		
4.	Do you have problems reading ? YES	☐ NO			
5.	Have you ever had an eye injury ? YES	□ NO	Describe:		
6.	Have you ever had eye surgery ? YES	□ NO	Describe:		
7.	Are you being treated for any medical conditions ?				
	Diabetes: YES NO	Heart Disease:	☐ YES ☐ NO	Stroke:	☐ YES ☐ NO
	High Blood Pressure: YES NO	Arthritis:	☐ YES ☐ NO	Other:	
8.	Are you currently using any eye medications ?	☐ YES ☐ NO	Describe:		
9.	Do you currently use:				
	Coumadin: YES NO Aspirin	: YES	S 🗌 NO	Plavix:	☐ YES ☐ NO
	Flomax: YES NO Omega	3 (fish oil): YE	ES 🗌 NO	Vitamin E:	☐ YES ☐ NO
10.	O. Please list any other medication you are currently taking:				
11.	Any known allergies ? YES NO Pleas	se describe:			
12	Do you have any family history of eye problems?	Dlagga girola and	Llist family relatio	nchin:	
12.			-	_	
	Glaucoma Cataract Macula	r Degeneration	Diabetio	e Eye Disease	Retinal Disease
	Patient Name:				
	Patients Signature: Date:				



Medical/Cosmetic Questionnaire

Please circle if you currently **HAVE** or **HAVE HAD** the following:

Please circle if you **HAVE HAD** or **WOULD LIKE TO HAVE** the following:

EYES: NONE

Corneal Injury/Scars Corneal Transplant Eye Hemorrhage Glaucoma

Macular Degeneration Retinal Detachment Tearing/Dry Eyes

OTHERS: NONE

Anemia Asthma

Arthritis

Bleeding/Blood Clotting

Blood Transfusion

Bone/Joint Disease

Bruise Easily

Cancer

Chemotherapy

Cough

Depression

Diabetes

Eczema

Emphysema (COPD)

Heart Disease/Attack/Bypass

Hepatitis

High Blood Pressure

High Cholesterol

HIV Disease

Infection(s)

Kidney Disease

Liver Disease

Migraine or Other Headaches

Pacemaker

Pneumonia

Psychiatric Care

Radiation Therapy

Rheumatic Fever

Seizure

Stroke (CVA)

Thyroid (Graves) Disease

Tuberculosis

Ulcer(s)

Other / Explain:

EYE/FACIAL IMPROVEMENTS

Blepharoplasty	Would Like
Cataract Surgery	Would Like
Drooping Eyelid Repair	Would Like
Eye Fat Pocket Reduction	Would Like
Reduction of Eye "Tearing"	Would Like
BOTOX Treatment(s)	Would Like
JUVÉDERM Treatment(s)	Would Like

(or other fillers)

LATISSE Treatment(s) Would Like PROVAGE MD Treatment(s) Would Like



Notification of Insurance Information Changes

We are committed to providing you with the best possible care. If you have insurance, we are happy to submit your claims for processing. Please submit to our office a copy of your new insurance card to inform us of any changes in your plan. Remember, your notification of any changes in your insurance must be submitted to us **before** service are rendered.

Please be advised that you will be responsible for payment for services if you do not notify us **before** services are rendered, of any changes in your insurance information. This would include changes in your medical group or IPA, health plan, primary physician, referring physician, benefits, and eligibility.

By signing below, I am stating that I have read and understand the above information, and I will bring *Newport Eye Physicians* a copy (of both sides) of my new insurance card when it changes.

Privacy Practices Acknowledgement

By signing below, I am stating that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and to ask any questions about it.

Authorization to Leave Messages

By signing below, I am giving my permission for the staff of <i>Newport Eye Physicians</i> to leave messages, either wi a live person or on my answering machine, regarding my health care, test results, and/or my appointments at th following phone number(s):					
Patient Name:					
Patients Signature:	Date:				