

Freedom Eye Care New Patient Form

New Patient Form

Please fill out *all* sections completely.

General Information:

Patient First Name:

Patient Last Name:

Patient Nick Name

Gender:

☐ Male

☐ Female

Pronouns:

Street Address:

City

State

ZIP Code

Email Address:

Cell Phone:

Date of Birth:

Social Security Number

Occupation:

Check off your preferred method of contact:

☐ Cell Phone

☐ Email

☐ Text message

How did you hear about our office?.

☐ Google

☐ Social Media

☐ Insurance

Referred by (Other/Name)

Current Vision

Date of Last Eye Exam:

Doctor if known:

Glasses

Do you currently wear glasses?

☐ Yes

☐ No

What type of lenses are in your glasses?

☐ Single vision

☐ Bifocal

☐ Trifocal

☐ Progressive

Contact Lenses:

Do you currently wear contact lenses?

☐ Yes

☐ No

What type of contact lenses do you wear?

- ☐ Soft ☐ Rigid Gas Permeable (RGP) ☐ Scleral Lenses
☐ Other

Specify

Are you interested in newer contact lens technology?

- ☐ Yes ☐ No

What is the manufacturer/model of your contact lenses?

What are the powers of your contact lenses?

Right

Left

How often do you replace your contact lenses? Check appropriate duration:

- ☐ Daily ☐ Weekly ☐ 2 weeks
☐ 1 Month ☐ 3 Months ☐ Other

Specify:

What solutions do you use to care for contact lenses?

- ☐ Opti Free ☐ Renu ☐ Clear Care
☐ Boston ☐ Biotrue ☐ Sensitive Eyes
☐ Other ☐ Don't know

Specify:

What is the main reason for your visit:

Check off any troubles you are having. :

- | | | |
|---|---|--|
| ☐ Blurry Distance Vision | ☐ Blurry near vision | ☐ Itchiness |
| ☐ Floaters | ☐ Poor night vision | ☐ Headaches |
| ☐ Burning | ☐ Flashes of light | ☐ Eye Strain |
| ☐ Double Vision | ☐ Watering eyes | ☐ Gritty feeling |
| ☐ Glare or reflections | ☐ Trouble reading/learning | ☐ Dry eyes |
| ☐ Redness | ☐ Soreness or pain | ☐ Light sensitivity |
| ☐ Other | | |

Specify:

Eye, Health and Family History:

List any eye surgeries or injuries (or write none):

YOUR EYE HEALTH : Current or previous

- ☐ Blindness ☐ Glaucoma ☐ Corneal Disease

- | | | |
|--|---|--|
| ☐ Cataracts | ☐ Age Related Macular Degeneration | ☐ Strabismus (eye turn) |
| ☐ Peripheral Vision Defects | ☐ Amblyopia (lazy eye) | ☐ Retinal Detachment |
| ☐ No problems | | |

List any EYE medications or Eye Drops

Check any medical conditions you have

- | | | |
|-----------------------------------|---|---|
| ☐ Diabetes | ☐ Hypertension | ☐ High Cholesterol |
| ☐ Thyroid | ☐ Cardiovascular | ☐ Cancer |
| ☐ Other | | |

Year Diagnosed:

Explain other medical condition

Primary Care Doctor(s):

List any injuries, surgeries or hospitalization if any:

List your current medications (or write none):

List any medicine allergies (or write none):

If female, are you pregnant?

☐ Yes

☐ No

How many weeks along?

Are you nursing?

FAMILY HISTORY

- | | | |
|------------------------------------|---|--|
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Cancer |
| ☐ Glaucoma | ☐ Amblyopia (lazy eye) | ☐ Strabismus (eye turn) |
| ☐ Cataracts | ☐ Macular Degeneration | ☐ No problems |

Smoking Status

- | | | |
|--|--|---|
| ☐ Currently every day smoker | ☐ Current some day smoker (not daily) | ☐ Former Smoker (no longer smokes) |
| ☐ Heavy smoker (>10 cigs/day) | ☐ Light smoker (<10 cigs/day) | ☐ Never smoker |

List your sporting activities/hobbies (or write none):

How many hours do you spend on digital devices per day? Average:

How many hours do you spend outdoors per day? Average:

Do you want information on LASIK vision surgery?

☐ Yes

☐ No

HIPAA: I understand that I am responsible for signing a new HIPAA consent once a year.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Freedom Eye Care to release any medical information that may be necessary for medical benefit or for processing submissions to my insurance company.

CONSENT FOR TREATMENT: I/We hereby authorize Freedom Eye Care to administer diagnostic and medical procedures as may be necessary for proper ocular health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance may be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

CONSENT FOR EMAIL COMMUNICATION: I consent Freedom Eye Care to send me information by e-mail and other electronic communications. I understand I can withdraw my consent at any time by contacting Freedom Eye Care at 512-916-4600 or by email at info@freedom-eyecare.com.

RETINAL PHOTOGRAPHY: Our doctors deem it necessary for all patients to receive a Retinal Photography on a yearly basis. This involves capturing a digital image of the retina in a non-invasive manner that eliminates the need for dilation for the majority of patients. This procedure allows for the

identification of various retinal conditions, including macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy.

CANCELLATION POLICY: I agree to provide 24 hours notice for any appointment cancellation. I understand that if I do not, I may be subject to pay a missed appointment fee of \$50.00.

Updated May 2023

Patient Signature

Date: