NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

LEGAL NAME (LAST, FIRST MIDDLE INITIAL)	MAIDEN NAME	MARITAL STATUS	SSN#	DATE OF BIRTH	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)

CITY, STATE, ZIP	HOME PHONE	CITY, STATE, ZIP	HOME PHONE
PRIMARY EMPLOYER	OCCUPATION	SECONDARY EMPLOYER (if applicable)	OCCUPATION

ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY

NAME (LAST, FIRST MIDDLE)	MARITAL STATUS	SSN#	DATE OF BIRTH	SEX

RELATIONSHIP TO PATIENT	OCCUPATION
ADDRESS	EMPLOYER
PHONE	EMPLOYER ADDRESS
IN AN EMERGENCY CALL:	WORK PHONE

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER
NAME OF INSURED	GROUP#
RELATIONSHIP TO PATIENT	DATE OF BIRTH

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY #
NAME OF INSURED	GROUP#
RELATIONSHIP TO PATIENT	DATE OF BIRTH

PHYSICIANS	PATIENT EMAIL/ PHARMACY
FAMILY PHYSICIAN	EMAIL
EYE DOCTOR/OPTOMETRIST	**PREFFERED PHARMACY**
REFERRING PHYSICIAN	

Who can have access to your **protected health** information, if you are not able/available to request information yourself?

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Name Relationship

Who may have access to your **billing/insurance** information if we call and are not able to discuss this information with you?

____

Name Relationship

Jennifer Burgoyne Dechant, M.D.

Name: ______________________________ Date of birth: __/__/___

Eye Drops: List all Eye drops you are using, and frequency. Or write "**NONE**".

______________ ________________

______________ ________________

______________ ________________

Past Eye History: Check the conditions you have now, or have had:

☐ Macular Degeneration	☐ Glaucoma
☐ Diabetic Eye Disease	☐ Cataracts
☐ Retinal Detachment	☐ Lazy or wandering Eye
☐ Dry Eyes	☐ Trauma

Previous Eye Surgeries: List and describe previous eye surgeries (include type, date and which eye) or write "NONE".

_______________________ __________________________ _________________________

_______________________ __________________________ _________________________

_______________________ __________________________ _________________________

SOCIAL HISTORY: Circle/check appropriate item

Smoking: YES / NO

Alcohol: YES / NO: drinks____per day / week

Home Status: **Marital Status:**

☐ Live alone	☐ Single
☐ With family	☐ Married
☐ Nursing home	☐ Widowed
☐ Assisted living	☐ Divorced

FAMILY HISTORY:

☐ Glaucoma
☐ Retinal Detachment/Blindness
☐ Macular Degeneration
☐ Other________________________

ALLERGIES TO MEDICATIONS: Please list allergy, severity, and the reaction if medication is taken. Or write "**NONE**".

ALLERGY:	**SEVERITY:**	**REACTION:**

SYSTEMIC ILLNESS: Please check all that apply. Please fill in any necessary blank spots.

☐ No history of illness	☐ Congestive Heart Failure	☐ Hepatitis/Liver disease ______________	☐ Lupus
☐ Anemia	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Rosacea
☐ Arrhythmia	☐ Diabetes Type 1 (how long)__________	☐ Cancer______________ ________________	☐ Depression/Anxiety
☐ Heart Attack	☐ Diabetes Type 2 (how long)__________	☐ HIV/AIDS	☐ Skin Cancer______ ______________
☐ Asthma	☐ Rheumatoid Arthritis	☐ Skin Disease	☐ Stroke
☐ Osteoarthritis	☐ Headache/Migraine	☐ Prostate Disease	☐ Thyroid disease ______________
☐ High Cholesterol	☐ Hearing Loss	☐ Lung Disease	☐ Sjogrens Syndrome

RACE:	ETHNICITY:	DESIRED LANGUAGE:
☐ American Indian	☐ Hispanic / Latino	☐ English
☐ Asian	☐ Non-Hispanic	☐ Spanish
☐ Black	☐ Unknown	☐ Vietnamese
☐ Pacific Islander	☐ Other	☐ Chinese
☐ White		☐ Arabic
☐ Other		☐ Other

SURGERIES: List all major surgeries that you have had performed and year.

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MEDICATIONS: List all drugs you currently take with dosages and why you take them. If you have a pre-made list, please attach.

MEDICATION	REASON FOR USE

Check all of the eye symptoms that you are currently experiencing:

☐ Blurry Vision	☐ Glare	☐ Tearing
☐ Burning	☐ Halos around lights	☐ Watering
☐ Distortions Shapes/lines	☐ Itching	☐ Difficulty Driving at night
☐ Droopy eyelids	☐ Irritation	☐ Difficulty reading
☐ Dry Eyes	☐ Foreign Body Sensation	☐ Difficulty with street signs
☐ Double Vision	☐ Mattering on eyelids	☐ Difficulty watching TV
☐ Flashes/Floaters	☐ Sensitivity to light	☐ Bump on eyelid/face
☐ High/Low Blood sugar	☐ Swelling	☐ Cloudy vision

Which of these symptoms is the most significant? ____________________________________

How long have your symptoms been going on for? _____ days _____weeks ______months _______years

Are your symptoms worse in your: RIGHT EYE / LEFT EYE / BOTH EYES

If in both eyes, which is worse: RIGHT EYE / LEFT EYE / BOTH EQUAL

Are your symptoms: _____mild _____moderate_____severe_____constant______intermittent

OUR PAYMENT POLICY

If you are covered by an insurance plan, please present your current insurance card(s) to the receptionist at the time of your first visit. If your insurance changes at any time, you must present the new card(s) to the receptionist at your next visit after the change. Our staff must have current information in order to process your claims. Because of the numerous insurance plans available, we will not be able to answer specific questions regarding your plan. Please contact your insurance company for plan specific information.

If you are not covered under an insurance plan, we will provide assistance to you by making arrangements for payment that will fit your individual circumstances. You may call our office for an estimated amount of service costs prior to your visit. Payment will be due at the time of service. We accept check, Visa, MasterCard, and Discover.

1. It is ***your*** responsibility to check with your insurance company prior to your first visit to determine if we are a participating physician with your insurance plan. Medicare Standard **does not** require a referral. HMO's such as Premier Blue, Coventry, Blue Select, and others **may** require a referral.

2. If ***your*** insurance plan requires you to have a referral from your primary physician, ***you*** are responsible for contacting your physician before each visit to our office. Please ask your physician to fax or mail a copy of the referral to our office prior to your visit. If you do not have an authorized referral, we will not refuse you care. However, our office and your insurance company recognize that without a referral, **you** are responsible for any charges related to services provided. We will bill you directly for charges not covered by a referral.

3. If your insurance plan requires a co-payment for your office visit, you will be expected to pay the co-pay amount at the time services are provided. You will be billed for any portion of services not covered by your insurance plan and for deductibles that are a part of your insurance plan. For your convenience, check, VISA, MasterCard, and Discover are accepted.

Our staff is committed to assisting you. If you have any questions, please ask.

I HAVE READ, AND I UNDERSTAND THE ABOVE PAYMENT POLICY

X______________________________________ ________________

Patient /Guarantor Signature Date

Updated 2/2016