MODERN EYES OPTOMETRY
RAHIM KANJI, OD • KIM-CHI PHAM, OD

# New Patient Form

## Paitent Information

Welcome to Modern Eyes Optometry. We are delighted to have you as a patient and we appreciate you choosing us for your eye care needs. Please take a few moments to complete the following information.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ M.I. ______ Last Name ______ Date of Birth ______

Street Address, Apt ______ City ______ State, Zip ______

Home Phone ______ Cell or Work Phone (Please Circle) ______ Email Address ______

Employer / Occupation ______

*Would you like to receive an email to sign up for our newsletter, reminders and other promotions?* ☐ Yes ☐ No

Person Responsible for Account (if patient is a minor) ______ Social Security Number (of person responsible) ______

## *How did you find us? (Please check all that apply)*

☐ Phone Book ☐ Internet ☐ Post Card ☐ Patient (Please Name) ______

☐ Insurance Listing ☐ Walk-By ☐ Other ☐ Doctor (Please Name) ______

## Primary Health Insurance Information

Name of Insurance Company ______ Identification Number ______

Primary Insured's / Sponsor's Name ______ Primary Insured's Date of Birth ______

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

## Secondary Health Insurance Information

Name of Insurance Company ______ Identification Number ______

Primary Insured's / Sponsor's Name ______ Primary Insured's Date of Birth ______

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

## Vision Insurance Information

Name of Insurance Company ______ Identification Number ______

Primary Insured's Name ______ Primary Insured's Date of Birth ______

Patient relationship to primary insured ☐ Self ☐ Spouse ☐ Child

## Please Read:

Please be advised that the patient is responsible for providing a current copy of his/her insurance cards and Photo ID. Your Photo ID is important to protect against medical identity theft. The patient is also responsible for obtaining and providing a referral when required by the insurance company. Without the required information it will be the responsibility of the patient to pay for the services rendered on the day of the visit. Please be aware that Medicare and many other health insurance companies will not cover charges for items which may include, but are not limited to, refractions or medical supplies, which may be part of your eye examination. Healthcare regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud. Non-covered service fees and co-payments are ***DUE ON THE DAY THE SERVICES ARE RENDERED.***

*OTHER SIDE* ➡

# Patient History

Primary Care Physician and Clinic Name ____________________ Primary Care Physician Phone Number ____________________

Last Health Exam ____________________ Last Eye Exam ____________________

| Current Medications (including eye drops): | Past Surgeries: (General and/or Eye Surgery, including LASIK) | Specific Allergies & Allergies to Medicines: |
|---|---|---|
| | | |

***Do you have or are currently experiencing any of the following? Check all the apply***

## Eye History

- Glaucoma ☐
- Cataracts ☐
- Macular Degeneration ☐
- Prior Retinal Detachment ☐
- Color Blindness ☐
- Glare / Light Sensitivity ☐
- Floating Spots ☐
- Flashing Lights ☐
- Burning, Itching, or Tearing ☐
- Sandy or Gritty Feeling ☐
- Redness ☐
- Eye Pain or Soreness ☐
- Previous Eye Injury ☐
- Previous Eye Surgery ☐
- Double Vision ☐
- Strabismus (Crossed Eyes) ☐
- Other (List Below) ☐

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## General Health Conditions

- Fever ☐
- Weight loss ☐
- Currently Pregnant ☐
- Thyroid Problems ☐
- Diabetes ☐
- Deafness ☐
- Sinusitis ☐
- Osteoarthritis ☐
- Rheumatoid Arthritis ☐
- Osteoporosis ☐
- Previous Stroke ☐
- Seizures ☐
- Headaches ☐
- High Blood Pressure ☐
- Chest Pain ☐
- Heart valve disease ☐
- Previous heart attack ☐
- High cholesterolAnemia ☐
- Cancer ☐
- Asthma ☐
- Chronic bronchitis ☐
- Wheezing ☐
- Shortness of breath ☐
- Kidney stones ☐
- Autoimmune disease ☐
- HIV / AIDS ☐
- Depression ☐
- Panic attacks ☐
- Anxiety ☐
- Other (List Below) ☐

____________________

## Family History

- Diabetes ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Cancer ☐
- Cataracts ☐
- Glaucoma ☐
- Macular Degeneration ☐

## PLEASE READ: DILATION CONSENT

***DILATION** of your eyes is part of a comprehensive eye examination.*

To dilate the eyes, drops are used to relax the muscle which controls the pupil size, allowing the pupil to fully open. A wait time of 20 minutes is required to allow the drops to take effect before the doctor can complete the dilation.

Side effects of dilation can include short-term blurred vision up close, and in some cases far away, as well as sensitivity to light. (Temporary sunglasses will be given to the patient to help with this side-effect.)

Patients with high prescriptions, new floaters and flashes, diabetes, and high blood pressure are STRONGLY advised to have their eyes dilated yearly. In addition, patients with a family history of glaucoma, macular degeneration or blindness should follow the same guidelines.

**REFUSAL TO HAVE YOUR PUPILS DILATED MAY CAUSE YOUR DOCTOR TO BE UNABLE TO DETECT CERTAIN DISEASES.**

Please check one of the following:

- ☐ I ***AGREE*** to have my eyes dilated (or give permission to have my child's eyes dilated, if the patient is a minor).
- ☐ I understand the importance of dilation but ***REFUSE*** to dilate my eyes today.
- ☐ I would like to ***DISCUSS*** dilation with the doctor.

By signing below, you are attesting that all information you have presented here is correct, accurate, and up to date.

____________________ ____________________

Signature of Patient OR Guardian (if patient is a minor) Date