EYE MEDICAL GROUP - Norman Eye Clinic

New Patient Form: *Please take a few minutes to complete this form. If you have any questions, we would be glad to help.*

Patient Information

Last name ______________________ First Name ______________________ MI ________
Sex __M or F__ Age __________ DOB ________ / ________ / ____________ SSN ________ – ________ – ____________
Address ______________________________ City ____________ State ____ Zip________
Cell Phone (_____)__________________ Home Phone (_____)__________________ Work Phone (_____)__________________
Email ______________________________ Parent/Guardian (If Applicable) ______________________________
Employer ______________________________ Occupation ______________________________
Emergency Contact ______________________ Phone (_____)________________ Relationship ________________

Today's Exam: (circle all that apply) Medical Glasses/Contacts Reason for Visit______________________________
Last Eye Exam: ____________ Referred by ______________________________

Insurance Information

☐ **Skip this section if we have a copy of your current insurance cards**

1)Primary Medical ______________________ ID __________________ Group ____________
2)Secondary Medical ______________________ ID __________________ Group____________
3)Primary Vision______________________ ID __________________ Group____________
4)Other____

Insured Name (if different from patient)______________________DOB _____ / _____ / _______SSN _____ - ___ - _______
Relationship to patient______________________________ Employer ______________________________

Medical History

(Circle "Yes" if applicable) Primary Care Physician______________________

Eye surgeries? Yes Type ______________________________ Dates______________________
Eye injuries? Yes Type ______________________________ Dates ______________________
Do you wear glasses? Yes Frequency ______________________ Age of Glasses ______________________
And contact lenses? Yes Type __________ Solution____________ Replaced every ____________Sleep? Yes ________
Personal or family history of: (If Family specify)

Glaucoma	Yes	Self / Family ________________				Macular Degeneration	Yes	Self / Family ________________	
Cataract	Yes	Self / Family ________________				Retinal Detachment	Yes	Self / Family ________________	
Dry Eyes	Yes	Foreign Body	Yes	Itchy Eyes	Yes	Watery Eyes	Yes	Painful Eyes	Yes
Red Eyes	Yes	Floaters	Yes	Eye Strain	Yes	Light Sensitivity	Yes	Difficult night driving	Yes
Flashes of Light	Yes	Eye Infection	Yes	Additional Eye Health Information:______________________________					

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Personal history of the following medical conditions:

Diabetes	Yes	Type 1 or Type 2 A1C value __		High Blood Pressure	Yes	High Cholesterol	Yes
Allergies	Yes	Cardiovascular Disease	Yes	Respiratory (e.g. Asthma)	Yes	Endocrine Disorder (e.g. Thyroid)	Yes
Headaches	Yes	Autoimmune Disease	Yes	ENT (e.g. Sleep apnea)	Yes	Infectious Disease (e.g. HIV)	Yes
Blood Disease	Yes	Neurological Disorder	Yes	Mental Disorder	Yes	Urinary Disorder (e.g. Prostate)	Yes
Muscle Disorder	Yes	Bone Disease	Yes	Cancer (Specify)	Yes	______________________	

Other or additional information (e.g. currently pregnant)______________________________
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If family history of any of the above medical conditions, specify:______________________________
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Allergic to any medications? (circle) None or Yes, specify: ______________________________
Smoke Yes Frequency ______________ Alcohol Yes Chemical Dependency:________ Yes

Please list any surgeries and approximate dates:______________________________

▪ *I have been informed and offered a copy of Eye Medical Group's Notice of Privacy Practices. (Please review the laminated privacy notice)*
▪ *I realize that Eye Medical Group is filing my insurance as a courtesy. In the event that my insurance does not pay as expected, I will be responsible for any balance due. I fully understand that insurance co-pays and all non-covered fees are due at the time of service. I hereby authorize Eye Medical Group to release all information necessary to secure the payment of benefits. I request that payment of authorized insurance benefits be made either to me or on my behalf to my physician for any services furnished to me by that physician. I authorize the use of this signature on all insurance submissions.*

______________________________ ______________________
Responsible Party Signature / Date Eye Medical Group Physician