Leet EyeCare

Gregory S. Leet, O.D. • **Kory P. Thoma, O.D.** • **Laura R. Evans, O.D.**
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NEW PATIENT HISTORY QUESTIONAIRE

GENERAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Sex: _____

Address: _____ City: _____ State:_____ Zip:_____

Preferred Telephone Number(s): _____

SSN: _____ - _____ - _____ Date of Birth: _____/_____/_____ Email: _____

Ethnicity *(Please circle)*: Hispanic or Latino
Native Hawaiian or Other Pacific Island
Not Hispanic or Latino

Race *(Please circle)*: American Indian or Alaskan Native
Asian
Black or African American
Hispanic
Native Hawaiian or Other Pacific Island
White

Preferred Language *(Please circle)*: English
Spanish

Communication Preference: Email / Telephone / Postal / Text

Occupation: _____ Employer/School: _____

Marital Status: _____ Spouse or Parent's Name: _____

MEDICAL CONDITIONS

Condition	Current	Family History
Cardiovascular	❑	❑
General/Constitutional	❑	❑
Endocrine	❑	❑
Gastrointestinal	❑	❑
Genitourinary	❑	❑
Ear/Nose/Throat	❑	❑
Hematologic/Lymphatic	❑	❑

Condition	Current	Family History
Immunologic	❑	❑
Integumentary (skin)	❑	❑
Muskuloskeletal	❑	❑
Neurological	❑	❑
Psychiatric	❑	❑
Respiratory	❑	❑

Please Explain _____

MEDICATION AND MEDICAL HISTORY

Current Medication(s). Please list all including topical medications: _____

_____

Medication Allergy Y / N Allergic to what? _____

Diabetes Y / N Type: _____ Date of Diagnosis: _____ Last A_1C: _____

High Blood Pressure Y / N

Have you had any major operations? Y / N Type & Year: _____

Name of family doctor: _____ Date of last visit: _____ / _____ / _____

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NEW PATIENT HISTORY QUESTIONAIRE - CONTINUED

SOCIAL HISTORY

Cigarettes/tobacco Y / N Alcohol Y / N

REVIEW OF OCULAR SYSTEM

Do you see an eye surgeon? Y / N If yes, name of surgeon: _____ Date of last visit: _____ / _____ / ____
Have you had any eye operations? Y / N Type & Year: _____
Have you had any eye injuries? Y / N Type & Year: _____
Do you have glaucoma? Y / N Cataracts? Y / N Macular Degeneration? Y / N
Other eye problems? Y / N What type?_____
Do you wear glasses? Y / N If no, are you interested in contact lenses? Y / N
Do you wear contacts? Y / N What type? _____
Date of last eye exam: _____ Doctor: _____

FAMILY HISTORY OF:

Glaucoma_____ Macular Degeneration_____ Retinal Detachment_____

MISCELLANEOUS

Whom may we thank for referring you? _____

INSURANCE/PAYMENT INFORMATION

Do you have vision insurance? Y / N Name of your vision insurance: _____

Do you have medical insurance? Y / N Name of your medical insurance: _____

FINANCIAL DISCLAMERS

We will attempt to verify your insurance eligibility for services and/or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment**.** Please check with your plan administrator if you have any questions regarding your eligibility. Initial_____

LIABILITY

I understand Leet EyeCare will bill my vision and/or health insurance. I know that I am responsible for any remaining balance after the claim is submitted. Should my insurance not cover the services that are submitted in full, I agree to pay any outstanding balance.

In cases of divorce, the individual who receives the care is responsible for all charges. We will not bill a divorced spouse for the patient's services. For minor patients, the responsible party bringing the minor patient to the clinic will be responsible for any co-pays or co-insurance at time of service. Initial_____

PRIVACY POLICY

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Leet EyeCare. Initial_____

REFRACTION FEE

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as VSP or EyeMed, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. The fee for a refraction is $37. My signature below verifies I understand the refraction fee. Initial_____

_____ _____
Patient/Guardian Signature Date