PLETT
FAMILY OPTOMETRY

NEW PATIENT QUESTIONNAIRE

Date: _____

Patient Information

Last Name: _____ First Name: _____ MI:_____ Sex: M F

Preferred Name: _____ SS#: _____/_____/_____ Birth Date: _____/_____/_____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____ Employer/School: _____

How did you hear about us: _____

Medical Insurance Information

Medical Insurance Plan: _____ Member ID: _____

Phone Number: _____ Vision Plan: _____

****Please be sure to provide a copy of your medical insurance card.**

Account Responsible Information

Last Name: _____ First Name: _____ MI: _____

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

SS#: _____/_____/_____ Birth Date: _____/_____/_____ Relationship to Patient: _____

Practice Polices

If you are using vision and/or medical insurance coverage for today's visit: I hereby authorize Plett Family Optometry to retrieve or exchange any information necessary to process my insurance claim. I will receive services with the understanding in the event that such coverage is denied, I will be held financially responsible. All deductibles, co-pays, non-covered services, and payment for materials are due on the date of service. Insurance information is required at the time of service. By signing below, you acknowledge that you have read and agreed to this statement.

Contact Lens Evaluation Fees: If you have insurance, your exam co-pay is for the comprehensive exam only. Wearing contact lenses are consider an elective form of vision correction, therefore the contact lens evaluation is not covered and you are responsible in full for this charge. Some insurance plans do allow a certain reimbursement for contact lenses in lieu of glasses. By signing below, you acknowledge that you understand there is an additional fee associated with the contact lens exam whether you are a current contact lens wearer or new to contact lenses.

Returned Check Fee: All returned checks will incur a $35.00 processing fee.

Notice of Privacy Practices: I (name printed above) have been presented with the Notice of Privacy Policy (HIPAA) of Plett Family Optometry and have been offered a copy of such policy for my records.

Patient Signature (parent/guardian if minor) _____ Date _____

Please turn over form and complete side two

Medical & Ocular History

Reason for today's visit: ☐ new glasses ☐ contact lenses ☐ dry eyes ☐ diabetic exam ☐ LASIK ☐ failed vision screening
☐ other _____

Please describe any concerns you may have regarding your eyes, vision, ocular health or disease prevention.

_____

_____

Last Eye Exam: _____/_____/_____ Doctor/Location: _____
Last Medical Exam: _____/_____/_____ Doctor/Location: _____

Do you use/wear… How old/type/comments (blurry, clear, scratched, discomfort, no issues)

Eyeglasses? ☐ No ☐ Yes _____
Contact Lenses? ☐ No ☐ Yes _____
Drug Store Readers? ☐ No ☐ Yes _____
Computer? ☐ No ☐ Yes How many hours per day? _____
Any special visual needs (sports, hobbies, safety, etc.)? _____

Please list all medications you currently take, including over the counter and why (for example: Lipitor for cholesterol):

_____

_____

_____

Are you…

Allergic to Medication? ☐ No ☐ Yes _____
Pregnant or Nursing? ☐ No ☐ Yes If yes, due date _____
Major injuries, surgeries, and/or hospitalizations: _____
Being treated for: ☐ HIV ☐ Hepatitis ☐ Gonorrhea ☐ Syphilis ☐ Other _____
Using tobacco, alcohol, and/or illegal drugs ☐ No ☐ Yes (type/amount/how long) _____

Review of Systems

Ocular	Self	Family	Relation	Medical	Self	Family	Relation
Lazy eye	☐	☐	_____	High blood pressure	☐	☐	_____
Eye turn/wandering	☐	☐	_____	Cholesterol	☐	☐	_____
Color 'blind'	☐	☐	_____	Diabetes	☐	☐	_____
Light sensitivity	☐	☐	_____	Thyroid	☐	☐	_____
Eyestrain	☐	☐	_____	Arthritis	☐	☐	_____
Floaters/spots	☐	☐	_____	Lupus	☐	☐	_____
Retinal Detachment	☐	☐	_____	Gastro-intestinal	☐	☐	_____
Blindness	☐	☐	_____	Cancer	☐	☐	_____
Cataracts	☐	☐	_____	Headaches/Migraine	☐	☐	_____
Glaucoma	☐	☐	_____	Head trauma	☐	☐	_____
Macular Degeneration	☐	☐	_____	Stroke	☐	☐	_____
Eye injury/surgery	☐	☐	_____	Neurological disorder	☐	☐	_____
Other _____	☐	☐	_____	Other _____	☐	☐	_____

Patient Signature (parent/guardian if minor)	Doctor Signature Date