Greater New Orleans Eyecare New Patient Intake Form

Patient Information

Patient Name: _____Date of Birth: _____

Address: _____City: _____

State: _____ ZIP Code: _____

Cell Phone: _____ Email: _____

Emergency Contact Name: _____Phone: _____

Relationship to Patient: _____ Current Patient? (Y/N): _____

Insurance Information

Vision Plan: _____

Medical Insurance: _____

Any changes in insurance? (Y/N): _____ New Insurance Details: _____

Ocular/Eye History

Have you experienced or been treated for any of the following? (Circle all that apply)

☐Crossed/Lazy Eye ☐Dry Eye ☐Glaucoma ☐LASIK/PRK ☐Macular Degeneration

☐Retinal Detachment ☐Cataract Surgery

☐Other Eye Conditions/Injuries (Describe): _____

☐ Family History of above conditions_____

Medical History

Have you experienced or been treated for any of the following? (Circle all that apply)

☐Allergies ☐Cancer ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Stroke ☐Autoimmune

☐Thyroid Condition ☐Depression/Anxiety

☐Other : _____

_____

☐ Family Hx of above? _____

Primary Doctor/Pediatrician: _____

Current Medications: _____

_____

Medication Allergies: _____

GNO Eyecare Annual Exam Questionnaire

Lifestyle Questions

1. Occupation: _____
2. How many hours per day do you spend on digital devices? _____
3. Do you have trouble driving at night? (Y/N): _____
4. Do you rub your eyes to improve your vision? (Y/N)_____
5. Have you used eye drops or felt the need for eye drops in the past 30 days? (Y/N)_____
5. Are you having trouble with current glasses/Contacts? (Y/N)_____
6. With current glasses/contacts, I need better? (Circle all that apply) Distance Computer Reading
7. I need new (Circle) Glasses Contacts Both

Symptoms

Are you experiencing any of the following? (Please circle all that apply):

☐ Blurred Vision ☐ Burning ☐ Discharge ☐ Double Vision ☐ Dryness ☐ Eye Pain ☐ Floaters/Flashes
☐ Headaches ☐ Itching ☐ Light Sensitivity ☐ Redness ☐ Gritty Sensation ☐ Halos Around Lights
☐ Eye Fatigue ☐ Other(Describe):_____

How long have you been experiencing these symptoms? _____

Optional Diagnostic Services

Would you be interested in our doctors discussing the following with you? (Check all that apply):
☐Red Eyes ☐Crows Feet ☐Bags under eyes ☐ Rosacea ☐ Contact Lenses ☐ Sunglasses
☐ Safety Glasses ☐ Computer Glasses ☐ Driving Glasses ☐ Occupational Glasses ☐ 2 pair Discount

Advanced Retina Image

Optomap - $35

A digital widefield photo capturing a detailed image of your retina. Help detect diseases such as glaucoma, macular degeneration, cataracts, diabetes, high blood pressure, retinal detachments, and some eye cancers**. It provides a detailed view of the eye without dilation**. Recommended annually for all patients. The image allows the doctors to track changes or progression of retina conditions. **(Circle one)**

Yes- I would prefer digital widefield imaging of my retina ($35)

No- I would prefer dilation to view my retina

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I agree to be personally responsible for the timely payment of services rendered. If I suspend or terminate my care/treatment, any fees for professional services rendered will be immediately due and payable. By signing below, I acknowledge that payment is due on the date of service. I understand that there will be a $35 fee for NSF and bounced checks. All sales are final.

Acknowledgment of Notice of Privacy Practices (NPP)

☐ Yes, I have read or had explained to me GNO Eyecare's statement of privacy practices. I wish to continue my care under said terms.
☐ No, I have not read the privacy practices, and I chose not to read them. I wish to continue my care under said terms.

Patient Signature: _____ Date: _____