HOMETOWN
EYE CARE

New Patient Information

Please update your information to the best of your ability.

What is the reason for your visit?		
PATIENT INFORMATION		
Name (First Middle Last):		
Date of Birth:	Social Security #:	Birth Gender : ☐ MALE ☐ FEMALE
Mailing Address:	City, State, Zip	
Email Address:	Primary Phone:	Okay to leave a message? ☐ Yes ☐ No
Primary Care Provider:		
Emergency Contact Name:	Relationship:	Phone:
Preferred Pharmacy Name:	Location:	
INSURANCE INFORMATION		
PRIMARY Insurance Co. Name:	Policy Number/Member ID:	Group Number:
Insured Name:	Insured Date of Birth:	Patient Relationship to Insured ☐ SELF ☐ SPOUSE ☐ DEPENDENT
Insurance Co. Address (found on the back of the card):		Phone:
SECONDARY Insurance Co. Name:	Policy Number/Member ID:	Group Number:
Insured Name:	Insured Date of Birth:	Patient Relationship to Insured ☐ SELF ☐ SPOUSE ☐ DEPENDENT
Insurance Co. Address (found on the back of the card):		Phone:
VISION Insurance Co. Name:	Policy Number/Member ID:	Group Number:
Insured Name:	Insured Date of Birth:	Patient Relationship to Insured ☐ SELF ☐ SPOUSE ☐ DEPENDENT
Insurance Co. Address (found on the back of the card):		Phone:

HOMETOWN EYE CARE

MEDICAL HISTORY

Please update your information to the best of your ability.

Patient Name			
Date of Birth			
Do you wear glasses?	☐ YES ☐ NO	Do you wear contacts ?	☐ YES ☐ NO
Do you have any interest in wearing contacts ? ☐ YES ☐ NO			
Any major eye injuries, surgeries, or diseases of the eye? ☐ YES ☐ NO			
If YES , please explain:			
Please list all medications:	*(Including eye drops, birth control, vitamins, etc.)*		

FAMILY HISTORY							
General	**Self**	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Stroke or TIA	☐	☐	☐	☐	☐	☐	☐
Seizures, Epilepsy	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes Type I	☐	☐	☐	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐
Anxiety or Depression	☐	☐	☐	☐	☐	☐	☐
Long-term Chronic Infection or Disease	☐	☐	☐	☐	☐	☐	☐
Amblyopia (Lazy Eye)	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐	☐

Social History		
Alcohol Consumption	☐ YES ☐ NO	If yes, how much per day?
Current Smoker	☐ YES ☐ NO ☐ QUIT	If yes, how much per day?

HOMETOWN EYE CARE

AUTHORIZATIONS

HIPAA AUTHORIZATION		
I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis and herby authorize and request Hometown Eye Care, PLLC to release my information to:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I understand that I am entitled to a copy of Hometown Eye Care, PLLC's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices and Insurance ABN at HometowneyecareNH.com or from the office directly. I understand that I have the right to revoke this authorization in writing at any time. **INTITAL:** _____
I hereby authorize Hometown Hometown Eye Care, PLLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payment for medical services rendered to my dependednt or myself. I understand that I am responsible for any amount not covered by my insurance. **INTITAL:** _____

PAYMENT POLICY
Payment for professional services is expected when services are rendered. A deposit is required on all orders, and the balance is due to be paid upon delivery of any eyewear or contact lenses. **INTITAL:** _____

Print Patient Name:	
Signature (Patient or Representative):	Date: