Welcome to Lerner Vision Care, LLC

New Patient Information Form

DATE OF APPOINTMENT: _____

Title: (circle)

Mr.

Ms.

Mrs.

Dr.

Other Title:

_____

Patient Name (Last, First, MI):

Date of Birth of Patient:

_____

Primary Vision Plan Name:

_____

Policy/ID Number: _____

Medical Ins Plan Name:

_____

Medical Insurance Policy/ID Number:

_____

Name of Primary Insurance Holder (Last, First, MI)
(if different from patient)

_____

Date of Birth of Primary Ins Holder (if different from patient)

_____

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Business Phone:

Occupation:

Email Address:

I Wear Contacts: (PLEASE BRING OLD RX IF POSSIBLE)

- Soft **OR** Rigid (please circle)
- _____ Hours per day
- _____ Days per week

– OR –

☐ **Mark the box if you do NOT wear contact lenses**

How did you hear about our office? (Please select ONLY ONE):

☐ For Eyes customer ☐ Military newspaper ☐ Through insurance
☐ Walk by/Drive by ☐ Online ☐ Referred by a friend/colleague
☐ Was Dr. Lerner's patient at this office
☐ Was Dr. Lerner's patient at the naval base
☐ Other (please specify) _____

I had my last eye exam (Please select ONLY ONE):

☐ Less than 1 year ago ☐ 1-2 years ago ☐ 2-3 years ago
☐ 3-4 years ago ☐ 5+ years ago ☐ 10+ years ago
☐ During childhood years ☐ Never ☐ Unknown

Special Visual Needs:

☐ Computer Glasses (anti-glare tints, coatings, etc.)
☐ Safety Glasses (woodworking, welding, etc.
☐ Occupational glasses (pilots, mechanics, etc.)

Reason(s) for Today's Exam (Check ALL that apply):

☐ Routine vision exam
☐ Eye(s) irritated/infected
☐ Need a new glasses prescription
☐ Need new contact lens prescription
☐ Interested in trying contact lenses
☐ Interested in LASIK
☐ Blurry distance vision correction
☐ Blurred near vision correction
☐ Failed school screening
☐ Other (specify below):

_____

Current Health History:

☐ Epilepsy
☐ Multiple Sclerosis
☐ Hypertension
☐ Atherosclerosis
☐ Heart Disease
☐ Heart Attack
☐ Stroke
☐ Asthma
☐ Emphysema
☐ Thyroid disorder
☐ Grave's disease
☐ Diabetes mellitus
☐ Elevated cholesterol
☐ Kidney disease
☐ Hepatitis
☐ Gout

Current Health History:

☐ Anemia
☐ Sickle cell anemia
☐ Rheumatoid arthritis
☐ Depression
☐ Insomnia
☐ AIDS ☐ HIV
☐ Lupus erythematosus
☐ Seasonal allergies
☐ Migraine headaches
☐ Cancer (specify below):

_____

☐ Other (specify below):

_____

☐ **Current tobacco user**
☐ **Former tobacco user**
☐ **Never used tobacco**

Family Health History:

☐ **Unknown**
☐ Hypertension
☐ Heart disease
☐ Stroke
☐ Diabetes mellitus
☐ Elevated cholesterol
☐ Anemia
☐ Sickle cell anemia
☐ Thyroid disorder
☐ Lupus erythematosus
☐ Rheumatoid arthritis
☐ Asthma
☐ Migraine headaches
☐ Other (specify below):

_____

CONTINUED ON NEXT PAGE…

Current Visual Symptoms: □ Blur at distance **with** glasses/contact lens correction □ Blur at near **with** glasses/contact lens correction □ Headaches □ Short reading span □ Slow focus recovery □ Loss of place reading □ Color deficiency □ Poor depth perception □ Squinting □ Glare/Light sensitivity □ Difficulty seeing at night □ Distorted vision (halos) □ Double vision □ Flashes □ Floaters/spots	**Current Ocular Symptoms:** □ Eye Fatigue □ Soreness □ Pain □ Heavy feeling/pressure □ Foreign body sensation □ Dry/sandy feeling □ Redness □ Burning □ Itching □ Watery/teary eyes □ Mucus like-discharge **Current Eye History:** □ Cataracts □ Color Deficiency □ Glaucoma □ Macular Degeneration □ Corneal dystrophies	**Current Eye History:** □ Keratoconus □ Retinal Detachment □ Strabismus (turned eye) □ Dry Eye Syndrome **Eye Surgeries** □ LASIK/PRK Surgery Date: _____ □ Cataract Surgery Date: _____ □ Retinal Surgery Date: _____ *** If you do not know the exact date, please approximate.** **MEDICATIONS:** □ **Check here if none** _____ _____ _____	**Family Eye History:** □ Amblyopia (lazy eye) □ Blindness (due to disease only) □ Color deficiency □ Corneal dystrophies □ Glaucoma □ Keratoconus □ Macular degeneration □ Retinal Detachment □ Strabismus (eye turn) □ Other (specify): _____ **ALLERGIES TO MEDICATION:** □ **Check here if none** _____ _____ _____ _____

In our continued effort to provide the most advanced technology available to our patients, we use **the Optomap laser screening ophthalmoscope** and the **Humphrey Matrix Visual Field Analyzer**. These instruments greatly enhance our ability to assess and monitor your eye health with these benefits:

Both tests take just a few minutes and do not require any drops.

Dr. Lerner recommends the Optomap AND Visual Field for patients ages 6 and up yearly.

The Optomap Retinal Exam:

The Optomap is a retinal imaging device that takes two digital retinal images of each eye creating a dilated view of the retina without the need to use eye drops.

- Fast, easy and comfortable
- We can see 200 degrees of the back of the eye vs. the 30 degrees seen during a non-dilated view of the back of the eye.
- We have a permanent record with which to compare and track potential eye disease.

Visual Field Exam:

The visual field allows us to pick up and diagnose conditions such as some forms of brain tumors, retinal detachments, glaucoma, macular degeneration, optic nerve disease, retinal infections, and other diseases and disorders. It is fast, inexpensive, accurate and will pick up conditions that are not always evident by looking inside the eye so it is an excellent adjunct to the Optomap.

Fees:

There is an additional charge of **$40.00** for the Optomap retinal exam and **$25.00** for the visual field exam. For both tests the fee is reduced to **$50.00 TOTAL**.

These fees are in addition to the regular exam fees.

Because your insurance is designed to cover only a basic eye exam, it does **not** cover advanced screening such as the Optomap or the visual field.

CONTINUED ON NEXT PAGE…

Please check the appropriate box regarding the **SUPPLEMENTAL TESTING** below and sign and date regarding vision plan/insurance acceptance.

☐ **I DO WANT** THE OPTOMAP **AND** VISUAL FIELD TESTS
(NO drops required) **($50 ADDITIONAL FEE**, NOT COVERED BY INSURANCE)

OR

☐ **I DO WANT** the Optomap only **(NO drops required)($40 fee)**

OR

☐ **I DO** want the Visual Field only **(NO drops required)($25 fee)**

OR

☐ **I DO NOT** want the Optomap or Visual Field testing

There is no extra charge for a dilated eye examination with eye drops.

Please note that dilation of the pupils has the following side effects: photophobia and blurry near vision. It also requires about 20 minutes additional time in the office. The side effects may last for approximately 3 to 6 hours.

☐ **I DO** prefer to have my eyes Dilated **(Drops are required)**

☐ **I DO NOT want to have my eyes dilated * (It is recommended to have a retinal evaluation either with dilation drops or retinal scan/photography at least every two years)**

I understand that this office accepts insurance/vision plans as a courtesy to patients. **In the event that the insurance company/vision plan denies the claim, I will pay any balance due.** Please sign below. We will keep your signature on file for your insurance.

X _____

SIGNATURE OF PATIENT / LEGAL GUARDIAN DATE HERE

- There will be a $25 fee for any returned checks –

Thank you for completing this form. (3 PAGES TOTAL)
You may fax your form to Lerner Vision Care at (301) 913-9264, or bring it with you the day of your appointment.