WELCOME TO OUR OFFICE

Date: _____

(Please Print)

[Section 1]

Name: _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Home: _____ **Work:** _____ **Mobile:** _____

Email: _____

Sex: ☐ M ☐ F **Age:** _____ **Date of Birth:** _____

Social Security# _____

Guardian's Name: _____ **DOB:** _____
(if patient is under 18)

Employer: _____

Occupation/grade: _____

How did you hear about us? _____

NuVue EYECARE

[Section 2]

Date of last eye exam: _____

Name of doctor/facility: _____

Do You currently wear eyeglasses? ☐Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No

Contact lens brand/type:

Brand of contact lens solution:

Would you like to be fitted for contacts lenses?
☐Yes ☐No

[Section 3]

Medical History

Please check all conditions that you currently or have you ever suffered from. List the medications associated with each condition and explain. Also, list any family members who have suffered from any of the conditions.

Condition	Yes	No	Explanation/Medication	Yes	No	?	Family Member (mother, grandfather, etc,)
Blindness	☐	☐		☐	☐	☐	
Cataracts	☐	☐		☐	☐	☐	
Lazy Eye	☐	☐		☐	☐	☐	
Glaucoma	☐	☐		☐	☐	☐	
Macular Degeneration	☐	☐		☐	☐	☐	
Retinal Detachment	☐	☐		☐	☐	☐	
Diabetes	☐	☐		☐	☐	☐	
Thyroid Disease	☐	☐		☐	☐	☐	
High Blood Pressure	☐	☐		☐	☐	☐	
High Cholesterol	☐	☐		☐	☐	☐	
Heart Disease	☐	☐		☐	☐	☐	
Hypertension	☐	☐		☐	☐	☐	
Cancer	☐	☐		☐	☐	☐	

Please list any other eye injuries, diseases, or conditions not listed above: _____

Are you allergic to any medications? If so please list them: _____

(The following information is strictly confidential, however, you may discuss this portion with Dr. Gavami personally if you prefer.)

Are you: ☐ **Pregnant or** ☐ **Nursing** **Do you use tobacco products?** ☐ **Yes** ☐ **No** Type/Frequency: _____

Do you drink alcohol? ☐ **Yes** ☐ **No** **Do you use illegal substances ?** ☐ **Yes** ☐ **No** Type/Frequency: _____

Do you suffer from any sexually transmitted diseases? ☐ **Yes** ☐ **No** Condition/Medication: _____

Please Complete Other Side

Review of Systems: **Please check all conditions that you currently or have ever suffered from**. List your medications associated with each condition,and explain. [Section 4]

Conditions	Yes	No	?	Explanation/Medication
Skin Conditions(Integumentary)	☐	☐	☐	
Neurological				
Headaches/Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
Eyes				
Loss/Blurred Vision	☐	☐	☐	
Loss of Side Vision	☐	☐	☐	
Double Vision	☐	☐	☐	
Dryness	☐	☐	☐	
Mucous Discharge	☐	☐	☐	
Sandy/Gritty Feeling	☐	☐	☐	
Itching Eyes	☐	☐	☐	
Burning Eyes	☐	☐	☐	
Tired Eyes	☐	☐	☐	
Foreign Body Sensation	☐	☐	☐	
Watering/Excessive Tearing	☐	☐	☐	
Light Sensitivity/Glare	☐	☐	☐	
Eye Pain/Soreness	☐	☐	☐	
Chronic Eye/Lid Infections	☐	☐	☐	
Stye/Chalazion	☐	☐	☐	
Flashes/Floaters in Vision	☐	☐	☐	
Ears, Nose, Mouth, and Throat				
Allergies/Hay Fever	☐	☐	☐	
Sinus Congestion	☐	☐	☐	
Runny Nose	☐	☐	☐	
Post-Nasal Drip	☐	☐	☐	
Chronic Cough	☐	☐	☐	
Dry Throat/Mouth	☐	☐	☐	
Respiratory	☐	☐	☐	
Asthma	☐	☐	☐	
Chronic Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
Constitutional				
Fever	☐	☐	☐	
Weight Loss/Gain	☐	☐	☐	
Thyroid/Other Glands (Endocrine)	☐	☐	☐	
Vascular/Cardiovascular				
Diabetes	☐	☐	☐	
Heart Pain	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Vascular Disease	☐	☐	☐	
Gastrointestinal				
Diarrhea	☐	☐	☐	
Constipation	☐	☐	☐	
Genitals/Kidney/Bladder (Genitourinary)	☐	☐	☐	
Bones/Joints/Muscles				
Rheumatoid Arthritis	☐	☐	☐	
Muscle Pain	☐	☐	☐	
Joint Pain	☐	☐	☐	
Lymphatic/Hematological				
Anemia	☐	☐	☐	
Bleeding	☐	☐	☐	
Allergic/Immunologic	☐	☐	☐	
Psychiatric	☐	☐	☐	

Please list any conditions not listed above (explain conditions and list medications):

[Section 5]

PLEASE READ CAREFULLY

Your eye exam includes much more than just checking your vision. It is of the utmost importance to assure that your eyes are healthy and disease free. In order for Dr. Gavami to examine your eyes adequately it may be necessary to have additional testing performed during the exam or at another scheduled appointment. Dr. Gavami will discuss the nature and the necessity of these tests with you before performing them. These test may incur additional fees which **may not** be covered under your Vision plan, but may be covered under your **Medical/Health insurance**. Therefore, **even if you do not currently have vision insurance**, please fill out the information below concerning your Medical/Health insurance and bring your insurance card and picture ID to the front desk. If you have any questions or concerns, please feel free to speak with a member of our staff. Thank you.

Vision Insurance

☐ No vision insurance

Name of insurance: _____

Insurance ID#: _____ **Group#:** _____

Are you the primary insured? ☐ **Yes** ☐ **No**
(If yes, skip section below)

Name of insured: _____

Social Security# _____ **Date of Birth:** _____

Employer: _____

Relationship to insured: ☐ **Spouse** ☐ **Dependent**

☐ Check if address and contact info is the same as page 1.

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____

Medical Insurance

☐ No medical insurance

☐ **Check if medical and vision are the same.**

Name of insurance: _____

Insurance ID#: _____ **Group#:** _____

☐ **Check if the info below is the same as in the left column**

Name of insured: _____

Social Security# _____ **Date of Birth:** _____

Employer: _____

Relationship to insured: ☐ **Spouse** ☐ **Dependent**

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____

*** If you have multiple vision insurance plans, please let a member of our staff know at the front desk.**

BY SIGNING BELOW YOU:

1) **Acknowledge receipt of Dr David Gavami's *Notice of Privacy Practices* in compliance with Federal H.I.P.P.A. laws.**
2) **Authorize NuVue Eyecare to use information such as name, phone number, and address to contact you with appointment reminders and information about new products, treatment alternatives, or other health related information. If this contact is made by phone, a message may be left with others who answer or on voicemail.**
3) **Authorize NuVue Eyecare to release any information required to process insurance claims. Also, authorize insurance benefits to be paid directly to NuVue Eyecare.**
4) **Agree that if your payment for services and/or materials rendered is uncollectable (i.e. returned check) or insurance reimbursement is denied (i.e. lapse in coverage, materials/services considered non-covered) that you will be responsible for payment. If a collection agency's involvement is necessary to collect payment, you will be responsible for collections costs (33% of amount due).**

Patient's name (printed): _____

Guardian's name (printed): _____
(if patient under 18yrs old)

Patient/Guardian's Signature: _____

Doctor's Signature: _____

Thank you for choosing NuVue Eyecare for you vision needs!!