

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) <ul style="list-style-type: none"> • Soft OR Rigid (please circle) • _____ Hours per day • _____ Days per week <li style="padding-left: 20px;">– OR – <input type="checkbox"/> Mark the box if you do NOT wear contact lenses			How did you hear about our office? (Please select ONLY ONE): <ul style="list-style-type: none"> <input type="checkbox"/> For Eyes customer <input type="checkbox"/> Military newspaper <input type="checkbox"/> Through insurance <input type="checkbox"/> Walk by/Drive by <input type="checkbox"/> Online <input type="checkbox"/> Referred by a friend/colleague <li style="padding-left: 40px;"><input type="checkbox"/> Was Dr. Lerner's patient at this office <li style="padding-left: 40px;"><input type="checkbox"/> Was Dr. Lerner's patient at the naval base <input type="checkbox"/> Other (please specify) _____ 		
I had my last eye exam (Please select ONLY ONE): <ul style="list-style-type: none"> <input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 2-3 years ago <input type="checkbox"/> 3-4 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> 10+ years ago <input type="checkbox"/> During childhood years <input type="checkbox"/> Never <input type="checkbox"/> Unknown 			Special Visual Needs: <ul style="list-style-type: none"> <input type="checkbox"/> Computer Glasses (anti-glare tints, coatings, etc.) <input type="checkbox"/> Safety Glasses (woodworking, welding, etc.) <input type="checkbox"/> Occupational glasses (pilots, mechanics, etc.) 		
Reason(s) for Today's Exam (Check ALL that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Routine vision exam <input type="checkbox"/> Eye(s) irritated/infected <input type="checkbox"/> Need a new glasses prescription <input type="checkbox"/> Need new contact lens prescription <input type="checkbox"/> Interested in trying contact lenses <input type="checkbox"/> Interested in LASIK <input type="checkbox"/> Blurry distance vision correction <input type="checkbox"/> Blurred near vision correction <input type="checkbox"/> Failed school screening <input type="checkbox"/> Other (specify below): _____ 	Current Health History: <ul style="list-style-type: none"> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Hypertension <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Grave's disease <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Elevated cholesterol <input type="checkbox"/> Kidney disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gout 	Current Health History: <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> AIDS <input type="checkbox"/> HIV <input type="checkbox"/> Lupus erythematosus <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Cancer (specify below): _____ <input type="checkbox"/> Other (specify below): _____ 	Family Health History: <ul style="list-style-type: none"> <input type="checkbox"/> Unknown <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Elevated cholesterol <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Lupus erythematosus <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Other (specify below): _____ 		
CONTINUED ON NEXT PAGE...					

Current Visual Symptoms: <input type="checkbox"/> Blur at distance with glasses/contact lens correction <input type="checkbox"/> Blur at near with glasses/contact lens correction <input type="checkbox"/> Headaches <input type="checkbox"/> Short reading span <input type="checkbox"/> Slow focus recovery <input type="checkbox"/> Loss of place reading <input type="checkbox"/> Color deficiency <input type="checkbox"/> Poor depth perception <input type="checkbox"/> Squinting <input type="checkbox"/> Glare/Light sensitivity <input type="checkbox"/> Difficulty seeing at night <input type="checkbox"/> Distorted vision (halos) <input type="checkbox"/> Double vision <input type="checkbox"/> Flashes <input type="checkbox"/> Floaters/spots	Current Ocular Symptoms: <input type="checkbox"/> Eye Fatigue <input type="checkbox"/> Soreness <input type="checkbox"/> Pain <input type="checkbox"/> Heavy feeling/pressure <input type="checkbox"/> Foreign body sensation <input type="checkbox"/> Dry/sandy feeling <input type="checkbox"/> Redness <input type="checkbox"/> Burning <input type="checkbox"/> Itching <input type="checkbox"/> Watery/teary eyes <input type="checkbox"/> Mucus like-discharge Current Eye History: <input type="checkbox"/> Cataracts <input type="checkbox"/> Color Deficiency <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Corneal dystrophies	Current Eye History: <input type="checkbox"/> Keratoconus <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Strabismus (turned eye) <input type="checkbox"/> Dry Eye Syndrome Eye Surgeries <input type="checkbox"/> LASIK/PRK Surgery Date: _____ <input type="checkbox"/> Cataract Surgery Date: _____ <input type="checkbox"/> Retinal Surgery Date: _____ * If you do not know the exact date, please approximate. MEDICATIONS: <input type="checkbox"/> Check here if none _____ _____ _____	Family Eye History: <input type="checkbox"/> Amblyopia (lazy eye) <input type="checkbox"/> Blindness (due to disease only) <input type="checkbox"/> Color deficiency <input type="checkbox"/> Corneal dystrophies <input type="checkbox"/> Glaucoma <input type="checkbox"/> Keratoconus <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Strabismus (eye turn) <input type="checkbox"/> Other (specify): _____ ALLERGIES TO MEDICATION: <input type="checkbox"/> Check here if none _____ _____ _____
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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 digital retinal images of each eye creating a large 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 **\$30.00** for the visual field exam. For both tests the fee is reduced to **\$55.00 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) (**\$55 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)(\$30 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 -