FLEMING
VISION CARE

NEW PATIENT FORM

Patient: _____

Date : _____

PATIENT INFORMATION

Patient Name & Preferred Name: _____

Date of Birth: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Patient Social Security Number _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Emergency Contact: _____ Phone Number: _____

Occupation/Employer: _____

Language, Race, Ethnicity: _____

INSURANCE INFORMATION

Name of Vision Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse

Name of Medical Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse

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MEDICAL HISTORY

Have your of an immediate family member experienced, or been treated for, any of the following? Circle all that apply.

Allergies:	Yes	No	Family
Arthritis	Yes	No	Family
Blood/Lymph Disorder	Yes	No	Family
Cancer	Yes	No	Family
Diabetes (Please Specify Type)	Yes	No	Family
Heart Disease	Yes	No	Family
High Blood Pressure	Yes	No	Family
High Cholestrol	Yes	No	Family
Kidney Disease	Yes	No	Family
Lupus	Yes	No	Family
Seizures	Yes	No	Family
Stroke	Yes	No	Family
Thyroid Dysfunction	Yes	No	Family

CURRENT MEDICATIONS

(Prescription and over-the-counter and dosage)

MEDICATION DRUG ALLERGIES

Are you pregnant or nursing?

Height: **Weight:**

Do you smoke?

Have you ever smoked?

EYE HISTORY

Date of Last Eye Exam?

Currently Wear Glasses?

Currently Wear Contacts? If Yes, Which Brand?

Reason for Today's Visit:

Have your or an immediate family member experienced or been treated for, any of the following? Circle all the apply.

Cataracts	Yes	No	Family
Crossed Eye	Yes	No	Family
Glaucoma	Yes	No	Family
Lasik or RK	Yes	No	Family
Lazy Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experience, any of the following? Check all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itchying
- ☐ Light Flashes
- ☐ Redness
- ☐ Sandy or Gritty Feeling

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Dr Fleming wants ALL patients to have the Optomap

Optomap is used to detect and evaluate symptoms of retinal detachment or eye disease such as glaucoma. It is also used for monitoring the progression of such disease. We are able to take a digital photo of the interor surface of the eye, including the retina, optic disc, macula, and posterior pole (fundus). There is an additional cost of **$34.00** for this exam.

Please initial the following you **DO** wish to have done today

_____**I DO** want to have this today.

Dilation is included in your routine exam and is recommended once per year.

_____ I **DO** want to have my eyes dilated today if deemed necessary by the doctor.

If you require a follow up visit there is no charge within 90 days. If it is after 90 days, the doctor may charge an examination fee.

Contact lenses require additional testing and more patient out of cost responsibility.

All Sales Are Final. Fleming Vision Care will not issue refunds as all products are custom to each patient.

I HEREBY AUTHORIZE FLEMING VISION CARE TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM. I ALSO AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I ACKNOWLEDGE THAT ALL INFORMATION ABOVE IS COMPLETE AND CORRECT. I ACKNOWLEDGE THAT I HAVE REVIEWED AND REQUESTED A COPY IF NEEDED OF THE FINANCIAL AND PURCHASE AGREEMENT. I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES, HIPAA.

Sign_____Date_____