T.W. Clyde, O.D.

Jason M. Jost, O.D

New Patient Registration

Welcome to Pikes Peak Eye Care. Thank you for choosing us for your eye care needs. We are committed to providing the best and most comprehensive care possible. Please take a moment to complete the following information. Any information we have on file will be updated.

Personal Information:

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Phone: Home: _____Cell: _____Work: _____

E-mail: _____

Communication Preference: Phone: ☐ Text: ☐ E-mail: ☐ Postal Mail: ☐

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Employers Name: _____Occupation: _____

Preferred Language: _____ Race: _____Ethnicity: _____

Parent or Guardian's Name: _____

Phone: Home: _____Cell: _____Work: _____

Address (If Different from Patient): _____

City: _____ State: _____ Zip Code: _____

Employers Name: _____Occupation: _____

Emergency Contact Person: _____ Phone: _____

Relationship to Patient: _____

Patient Name: _____

Medical Information:

Referred By: _____ Referral Date: _____

Pharmacy Preference: _____ Location: _____

Telephone Number: _____

Financial Information:

Person Responsible for Fees: (Parent accompanying minor is responsible.) We accept cash, check, Care credit, and credit card for payment on your account.

Vision Insurance Company: _____Insurance ID No._____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____
Policy Holder's Social Security Number: _____ Policy Holder's Employer: _____

Relationship to Patient: _____

Primary Medical Insurance Company: _____ Insurance ID No._____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____
Policy Holder's Social Security Number: _____ Policy Holder's Employer: _____

Relationship to Patient: _____

Secondary Medical Insurance Company: _____Insurance ID No._____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____
Policy Holder's Social Security Number: _____ Policy Holder's Employer: _____

Relationship to Patient: _____

Some health insurance carriers will not cover eye examinations for the purpose of obtaining glasses. Most carriers will not cover the refraction fee (strength of the lenses) for determination of appropriate lenses. If you have a vision plan, all or a portion of these charges may be covered. You will be responsible for those charges determined by your insurance as a non-covered which is your portion. If you do not have insurance, we expect you to pay for your visit, glasses, or contacts at the time of your service. Thank you.

Signature: _____Today's Date: _____

Patient Medical History

Please fill out as completely as possible.

Name _____ **Date** _____ **Last Eye Exam** _____
Last Physical Exam_____ **Pregnant Y** ____ **N** _____
Use of Alcohol Yes_____ **No** _____ **How often? Never** ___ **Rarely** ___ **Moderate** ___ **Daily** ___
Use of Tobacco Yes ___ **No** ___ **Current Packs / Day** _____

Do you currently wear glasses: Yes___ **No** ___ **Contact Lenses: Yes** ___ **No**___ **Type:** _____
Reason for visit today: Glasses, Contact Lens, Other _____

Are you experiencing any of the following eye conditions (Circle all that apply)

Visual:

Headaches | Loss of place while reading | Covers one eye reading | Head Tilt | Poor depth perception
Doubling | Glare

Ocular:

Eye Fatigue | Foreign body sensation | Pain | Watery Eyes | Sensitive to light (Photophobia)
Dry / Sandy | Redness/Burning/Itching (Some/Extreme) | Discharge (Mucus/Milky)

Please indicate any medical conditions which you or a blood relative have been diagnosed. Indicate the relationship between you and the blood relative: Self, Parent, Siblings, Aunt, Uncle, Maternal (m) or Paternal (p) grandparent.

Ocular History:	**Self**	**Family Member**		**Self**	**Family Member**
Blindness	____	_____	Cataracts	____	_____
Color Blindness	____	_____	Flashes/Floaters	____	_____
Glaucoma	____	_____	Macular Degeneration	____	_____
Other: _____	____	_____			
Cardiovascular History:					
Cardiovascular Disease	____	_____	Elevated Cholesterol	____	_____
Hypertension	____	_____	Myocardial Infarction	____	_____
Stroke	____	_____	Other: _____	____	_____
Constitutional History:					
Car Sickness:	____	_____	Dizziness	____	_____
Other: _____	____	_____			
Endocrine History:					
Diabetes Mellitus	____	_____	Thyroid Disorder	____	_____
Other: _____	____	_____			
Head History:					
Headaches	____	_____	Headaches (Migraine)	____	_____
Other: _____	____	_____			
Immunologic History:					
HIV Positive	____	_____	Sjogren's Syndrome	____	_____
Other: _____	____	_____			
Integumentary History:					
Acne Rosacea	____	_____	Lupus	____	_____
Other: _____	____	_____			
Musculoskeletal History:					
Arthritis	____	_____	Arthritis Rheumatoid	____	_____
Myasthenia Gravis	____	_____	Other: _____	____	_____
Neurological History:					
Bell's Palsy	____	_____	Epilepsy	____	_____
Multiple Sclerosis	____	_____	Other: _____	____	_____
Psychiatric History:					
Attention Disorder (ADD)	____	_____	Alzheimer's Disease	____	_____
Other: _____	____	_____			

Diabetic Patients: Type 1 / Type 2: Please provide us with the last A1C Date and Results: _____

Previous Hospitalizations / Surgeries: **Date:**

_____ _____
_____ _____
_____ _____

All current medications you are taking include any non-prescription medications, and eye drops:

_____
_____
_____

Do you have any allergies (Medications / Other Substances / Seasonal):

_____
_____
_____

Pikes Peak Eye Care

710 N. Circle Drive

Colorado Springs, CO 80909

Phone: (719) 632-1587

ACKONWLEDGE OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have been provided Pikes Peak Eye care's Notice of Privacy Practices ("Notice"):

- The Notice tells me how Pikes Peak Eye Care will use my health information for the purposes of my treatment, payment for my treatment, and referral providers.

- The Notice explains in more detail how Pikes Peak Eye Care may use and share my health information for other than treatment, payment, and health care operations.

- Pikes Peak Eye Care will also use and share my health information as required or permitted by law.

- I consent Pikes Peak Eye Care to use and disclose my treatment and evaluation records maintained by Pikes Peak Eye Care for the purposes detailed in the Notice of Privacy Practices.

Patient's Name: _____Today's Date: _____

Signature: _____

(Responsible Party over the age of 18 years of or Accompanying Parent/Guardian)