New Sight
Vision Therapy Clinic

Welcome to our Office!

Patient Information

Name: _____

Address: _____

City, State, ZIP_____

Parent / Guardian:_____

Email: _____

Date of Birth: _____/_____/_____

Home Phone: _____

Cell Phone: _____

Preferred Contact Method: □ Home Phone □ Cell Phone □ Text □ Email

Patient Gender: _____

Patient Marriage Status: □ Single □ Married □ Divorced

Patient Occupation/ School Grade: _____

How did you hear about our office? □ Insurance □ Google □ COVD.org □ Doctor Referred □ Friend/Family Member □ Other

Please specify name: _____

Insurance Information

Medical Insurance:_____

Policy/ ID #_____

Name of Policy Holder:_____

Date of Birth:_____

Vision Insurance:_____

SSN/Policy/ID#_____

Name of Policy Holder:_____

Date of Birth: _____

Social Security Number: _____/_____/_____

Vision Needs

What is your main reason for coming here today? _____

Have you ever worn glasses? ❑Yes ❑No Do you wear glasses now? ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer work ❑ sports

What sports or hobbies are you involved in? _____

Are you interested in trying contact lenses? ❑Yes ❑No

Do you wear contact lenses at this time? ❑Yes ❑No What type? _____

Have you had problems wearing contact lenses? ❑Yes ❑No Describe _____

Do you drive? □ yes □ no If yes, do you have visual difficulty when driving? □ yes □ no (If yes, please describe:)

_____

Are there times when your vision (or present lens) isn't quite right? _____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

Are you experiencing any of the following?

Loss of Vision, Double Vision, Blurred Vision, Distorted Vision/Halos, Loss of Side Vision, Eye Pain or Soreness, Dryness, Mucous Discharge, Redness, Sandy or Gritty Feeling, Itching, Burning, Foreign Body Sensation, Excess Tearing/Watering, Glare/Light Sensitivity, Chronic Infection of Eye/Lid, Styes or Chalazion, Flashes/Floaters in Vision, Tired Eyes

Please explain _____

* *Please turn this form over and complete the other side* *

*320 W. River Park Drive #245, Provo, UT 84604 * P: (801) 800-8508 * F: (801) 341-0266 * NewSightVT.com*

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Social Health History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
☐ Yes, I would prefer to discuss my Social History information directly with my doctor. *(Check box)*

Do you use tobacco products? ☐ yes ☐ no If yes, type/amount/how long:_____

Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long:_____

Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Health History

Do you have any allergies to medications? ❑ yes ❑ no If yes, please explain:_____

_____

List or attach any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies:

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Are you pregnant and/or nursing? ❑ yes ❑ no

Please check any conditions that apply to you or your family (parents, grandparents, siblings, children; living or deceased):

ALLERGIC		
Allergies/Hay Fever	❑Self	❑ Family
NEUROLOGICAL		
Headaches	❑Self	❑ Family
Migraines	❑Self	❑ Family
Seizures	❑Self	❑ Family
RESPIRATORY		
Asthma	❑Self	❑ Family
VASCULAR / CARDIOVASCULAR		
Diabetes	❑Self	❑ Family
High Blood Pressure	❑Self	❑ Family
Vascular Disease	❑Self	❑ Family
Bleeding Problems		
GASTROINTESTINAL	❑Self	❑ Family
INTEGUMENTARY (Skin)	❑Self	❑ Family
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	❑Self	❑ Family
ENDOCRINE		
Thyroid/Other Glands	❑Self	❑ Family
VISION		
Blindness	❑Self	❑ Family
Glaucoma	❑Self	❑ Family
Cataract	❑Self	❑ Family
Crossed Eyes	❑Self	❑ Family
Lazy Eye	❑Self	❑ Family
Macular Degeneration	❑Self	❑ Family
Retinal Detach/Disease	❑Self	❑ Family

Authorization & Release

I have read and agree to the cancellation policy Initials_____

Eye care services and products are recommended for your optimum eye health and vision needs. We expect that your insurance will cover the majority of services provided. However, there may be some items that your insurance does not cover. You are responsible for the remaining balance. The fact that your insurance company may not pay for a particular item or service does not mean you should not receive it. (*by signing below, you agree to the above statement*)

Printed Name_____

Signature_____ Date_____

* *Please turn this form over and complete the other side* *