



## New Patient Form

Today's Date \_\_\_\_\_ Date of last exam \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(last) (first) (mi)

Address, City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Occupation \_\_\_\_\_ email address \_\_\_\_\_

Eye Care Insurance \_\_\_\_\_ Major Medical Ins \_\_\_\_\_

Are you a current patient of  Dr Gelarden  Dr Koval  Dr Markley or  New patient to our office?  
New Patient Referred by:  Sign  Insurance  Mail  Ad  other  friend \_\_\_\_\_

Are you buying glasses today?  YES  NO  ONLY IF PRESCRIPTION CHANGES

Do you currently wear contact lenses?  YES  NO

Are you interested in being evaluated for a laser vision correction?  YES  NO

List any problems you are having with your eyes or your vision \_\_\_\_\_

### MEDICAL HISTORY

Do you **PERSONALLY** have a history of any of the following conditions? (Please mark all that apply)

- Asthma  Cancer  Cataracts  Diabetes  Eye injury  LASIK  Glaucoma  Headaches  
 Seasonal allergies  Heart problems  High blood pressure  Macular degeneration  Stroke  Thyroid disease  
 Burning eyes  Glare at night  Eyes itch  Eyes water  Red eyes  Scratchy eyes  Sunlight sensitivity

If diabetic, how many years have you had diabetes? \_\_\_\_\_

Does anyone in your **FAMILY** have a history of the following conditions? (Please mark all that apply)

- Glaucoma  Macular degeneration  Retinal detachment  other eye disease not listed \_\_\_\_\_

Which family member: \_\_\_\_\_

Medications you currently take: \_\_\_\_\_

Medications you are allergic to: \_\_\_\_\_

Eye drops you are currently using: \_\_\_\_\_

I would like to learn more about... (Check all that apply)

- Laser Vision Correction  Prescription or Non-Prescription sunglasses  
 Bifocal Contact Lens Option  Light Weight Thin Lenses  
 High Definition Lenses

Professional fees are due at the time of service and are not refundable. I understand that I will be responsible for fees not covered by insurance. I have been offered a copy of the Notice of Privacy Practices.

Signature \_\_\_\_\_

(If patient is under 18 years of age, parent or guardian signature required)