NEW PATH VISION

PERSONALIZED EYE CARE | POTTSTOWN, PENNSYLVANIA

1100 Heritage Drive, Pottstown, PA 19464

610-326-2754 | office@newpathvision.com

New Patient Information Packet

Please complete before your first visit. Fields marked optional may be left blank.

PATIENT INFORMATION

Legal first name | **Middle** | **Last name**

Preferred name | **Date of birth (MM/DD/YYYY)** | **Pronouns (optional)**

Street address

City | **State** | **ZIP**

Mobile phone | **Other phone** | **Email**

Preferred routine contact method: ☐ Phone ☐ Text ☐ Email

EMERGENCY CONTACT

Name | **Relationship** | **Phone**

CARE TEAM AND PHARMACY

Primary care clinician | **Phone** | **Referring clinician (if any)**

Preferred pharmacy | **Pharmacy phone**

RESPONSIBLE PARTY / GUARANTOR

Complete only if someone other than the patient is financially responsible.

Name | **Relationship** | **Phone**

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Health and eye history

REASON FOR VISIT AND CURRENT CONCERNS

What brings you in today?

Current eye / vision symptoms (check all that apply):

- ☐ Blurred vision
- ☐ Fluctuating vision
- ☐ Eye pain
- ☐ Redness
- ☐ Burning / stinging
- ☐ Gritty / foreign-body feeling
- ☐ Excessive tearing
- ☐ Light sensitivity
- ☐ Headaches
- ☐ Flashes / floaters
- ☐ Double vision
- ☐ Contact lens discomfort

EYE HISTORY

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Diabetic eye disease
- ☐ Dry eye disease
- ☐ Retinal disease
- ☐ Eye injury
- ☐ Amblyopia / lazy eye
- ☐ Strabismus / eye turn
- ☐ Keratoconus
- ☐ Eye infection
- ☐ Other

Prior eye surgeries / procedures and approximate dates

Vision correction currently used: ☐ Glasses ☐ Contact lenses ☐ Reading glasses

Last eye exam (approximate date)

Previous eye doctor / practice

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Medical history, medications, allergies and family history

MEDICAL HISTORY

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart / vascular disease
- ☐ High cholesterol
- ☐ Thyroid disease
- ☐ Autoimmune disease
- ☐ Kidney disease
- ☐ Neurologic condition
- ☐ Cancer history
- ☐ Sleep apnea / CPAP
- ☐ Asthma / lung disease
- ☐ Migraine / chronic headache
- ☐ Arthritis
- ☐ Pregnant / nursing
- ☐ Other

Other significant medical conditions, hospitalizations, or surgeries

MEDICATIONS AND SUPPLEMENTS

List prescription medicines, non-prescription medicines, vitamins and supplements. Attach a current list if easier.

Medication / supplement	Dose / frequency
1	
2	
3	
4	
5	
6	

ALLERGIES AND REACTIONS

	Reaction
Medication / material allergy	
Additional allergy	

FAMILY EYE HISTORY

- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retinal disease
- ☐ Blindness / severe vision loss
- ☐ Keratoconus
- ☐ Other

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Insurance and benefit information

MEDICAL INSURANCE

Insurance company	Member ID	Group #

Subscriber name	Subscriber DOB	Relationship to patient

VISION BENEFIT PLAN

Vision plan	Member ID	Group #

Subscriber name	Subscriber DOB	Relationship to patient

SECONDARY MEDICAL INSURANCE (IF APPLICABLE)

Insurance company	Member ID	Group #

Important coverage reminder

Insurance participation and coverage are not the same thing. Benefits, deductibles, copays, authorizations and coverage for specific tests, procedures, materials or treatments vary by plan. Please bring current medical and vision insurance cards. Patients are encouraged to verify benefits with their plan when coverage is important to a care decision.

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Consents and acknowledgments

CONSENT TO CARE

I request evaluation and care from New Path Vision and authorize its licensed clinicians and staff to provide eye-care services that are appropriate to my visit and within their professional scope. I understand that recommended tests, treatments, referrals and follow-up may depend on clinical findings and that I may ask questions before care is provided.

INSURANCE BILLING AND FINANCIAL RESPONSIBILITY

I authorize New Path Vision to submit claims and information reasonably necessary for payment of covered services, consistent with applicable law and payer requirements. I understand that benefit quotations are not guarantees of payment, and I am responsible for patient balances that are properly due under my plan and applicable agreements.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I received or was provided access to New Path Vision's current Notice of Privacy Practices, available at newpathvision.com/notice-of-privacy-practices, and that I may request a paper copy. My signature acknowledges receipt or access to the notice; it is not an authorization for uses or disclosures beyond those permitted by law.

- ☐ I received or was provided access to the Notice of Privacy Practices.
- ☐ I would like a paper copy of the Notice of Privacy Practices.

ROUTINE COMMUNICATION PREFERENCES

Choose how the practice may contact you for routine scheduling, reminders and administrative matters. Do not use ordinary email or general website messages to send sensitive medical information unless the practice specifically directs you to a secure method.

- ☐ May leave a routine voicemail
- ☐ May send routine text messages
- ☐ May send routine email messages

Patient certification

I certify that the information I provided is accurate to the best of my knowledge and I will tell the practice about material changes.

Patient / Authorized Representative Signature

Date

Printed name

Relationship if signing for patient