

# Dr. Howard Budner & Associates

## New Patient Information

Welcome to our office! Please help us serve you best by giving us your information. Thank you!

Today's Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male / Female \_\_\_\_\_ Married/Partner \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_

Address: \_\_\_\_\_

Phone - Cell: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ (Full Time / Part Time) Job Title: \_\_\_\_\_ Student \_\_\_\_\_

### PATIENT'S MEDICAL INFORMATION (Please circle all that apply)

Do you currently, or have you ever had any problems in the following areas:

**Allergies**    **Arthritis**    **Cancer**    **Cardiovascular Disorder**    **Cholesterol**    **Diabetes**    **Endocrine**  
**Gastrointestinal**    **Headaches/Migraines**    **Heart Disease**    **High Blood Pressure**    **Immune Disorder**    **Kidney Disease**  
**Lupus**    **Musculoskeletal**    **Neurological Disorder**    **Pregnant**    **Nursing**    **Skin Disorder**    **Thyroid Disease**

**Other:** \_\_\_\_\_ **MEDICATIONS USED** (Please provide a complete list if possible): \_\_\_\_\_

\_\_\_\_\_  
**Medication Allergies:** \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### PATIENT'S EYE HISTORY (Please circle all that apply)

**LAST EYE EXAM:** \_\_\_\_\_ **LAST CONTACT LENS EXAM/FITTING:** \_\_\_\_\_

**Eye Surgery:** (Year \_\_\_\_\_, Please describe \_\_\_\_\_) **LASIK/PRK** (Year: \_\_\_\_\_)

**Eye Injuries:** (Year \_\_\_\_\_ Please describe \_\_\_\_\_) **Treated Eye Infection**

**Blindness**    **Cataracts**    **Crossed Eyes**    **Drooping Eyelid**    **Glaucoma**    **Lazy Eye**    **Macular Degeneration**    **Retinal Disease**

**GLASSES:** Distance    Reading    Multifocal    Prescription Sunglasses    **LAST GLASSES PURCHASE:** \_\_\_\_\_

Do you have the(se) glasses with you today? Yes / No

**CONTACTS: RGP/Hard** – (Single Vision / Bifocal) **Soft** – (Quarterly / Monthly / 2-Week / 1-Day) (Single Vision / Bi-focal / Mono-Vision)

Do you have these contact lenses with you today? Yes / No    Which disinfection solution do you use? \_\_\_\_\_

Brand Name of your Contact Lenses (if known): \_\_\_\_\_ How old are the pair you are wearing? \_\_\_\_\_

Number of hours spent on the computer/day: \_\_\_\_\_ Number of hours spent on close-up work/day: \_\_\_\_\_

Do you drive a car? Yes / No    Do you drive at night? Yes / No    Do you have any difficulty seeing while driving? Yes / No

### REASON FOR YOUR VISIT TODAY (Please circle all that apply)

**Annual/Routine Exam**    **Annual/Eyeglass Prescription**    **Annual/Contact Lens Fitting**    **Medical Problem/Medical Follow-up**  
**Problem w/Distance Vision**    **Problem w/Near Vision**    **Problem w/Computer Vision**    **Dry Eyes**    **Excessively Watery Eyes**  
**Flashes**    **Floaters**    **Decreased Peripheral Vision**    **Problem w/Glare or Light Sensitivity**    **Problem w/ Night Driving**

Interested in LASIK Vision Correction Other \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

(Please circle any that apply to biological parents, grandparents, siblings or children; living or deceased)

**Glaucoma**      **Macular Degeneration**      **Cataract**      **Retinal Detachment/Disease**      **Crossed Eyes**      **Blindness**  
**Diabetes**      **High Blood Pressure**      **Heart Disease**      **Kidney Disease**      **Thyroid Disease**      **Cancer**      **Lupus**  
**Arthritis**      **Other:** \_\_\_\_\_

**SOCIAL HISTORY**

Do you drink alcohol? Yes / No      Do you use tobacco products? Yes / No      Do you use illegal drugs? Yes / No

**GUARANTOR'S INFORMATION** (Insurance Plan Member – Parent, Spouse, Guardian)

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**INSURANCE INFORMATION** (Please list & provide cards to staff)

**Medical Insurance Provider:** \_\_\_\_\_ ID #: \_\_\_\_\_  
**Secondary Medical Provider:** \_\_\_\_\_ ID#: \_\_\_\_\_  
**Vision Insurance Provider:** \_\_\_\_\_ ID#: \_\_\_\_\_  
**Secondary Vision Provider:** \_\_\_\_\_ ID#: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Vision Insurance Listing      Medical Insurance Listing      Internet Search (Yelp, Google, Demandforce, ZocDoc, Other)  
Patient Referral: \_\_\_\_\_ Dr. Referral: \_\_\_\_\_

**OUR COMMITMENT TO YOU**

It is the policy of this office to keep your information confidential and require your permission to release information to another person. If you should need your medical records released, a form will need to be signed by you requesting that we do so. However, by signing below, you are giving us permission to release your information to the insurance carriers we bill or contact on your behalf and any doctor whom we refer you to, should it become necessary.

Our doctors and staff wish to provide you with the best possible care at all times, strive to answer all your questions to the best of our ability and hope you leave our office knowing we truly appreciate the choice you make to come to us for your eye care needs.

**PATIENT RESPONSIBILITIES**

I understand that I am responsible for providing the correct medical and/or vision insurance information for this date of service on or before the services are rendered and acknowledge that I will be responsible for any services not covered, for co-pays or co-insurance. I acknowledge that I have been made aware of the HIPPA notice of privacy practices, and that there are additional charges for contact lens services. I understand that you will bill the medical and/or vision plans for services and/or products provided by this office on my behalf whenever appropriate to do so. I understand that my bill today may not be the final amount because my insurance plan must be billed or due to changes that may occur to my material order(s) (such as a change in contact lens brand or type).

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_