New Patient Intake Form
Date: _______________

Dr. Andrew Tran, OD & Dr. Van Mai Vu, OD
112 E. Dixie Ave, Leesburg, FL 34748

EYECARE CENTER OF LEESBURG

Patient Name: ____________________________________ Phone: H __________________ W __________________
Patient Nickname: ________________________________ C __________________, Cell Carrier ____________
Date of Birth: ___/___/_____ Age _____ Sex: ❑ M ❑ F ❑ T Email: ____
Ethnicity: _________________ SSN #: ____ - ___ - ______
Address: ____

I prefer to be contacted via... (check ONE)
❑ Email ❑ Home phone ❑ Work phone ❑ Cell ❑ Text ❑ Mail

Occupation: ____
Employer: ____
Hobbies: ____
Spouse's Name: ____________________________________
Primary Care Doctor: ______________________________
Special Needs: ❑ Hearing Impaired ❑ Translator ❑ Wheelchair

If responsible party is not the patient, please complete below:
Guardian's Name: ______________________________
Relationship to Patient: ________________________
Address: ______________________________________
Phone: ___________________ SSN#: ____ - ____ - ______

Insurance Information

Primary Insurance Carrier __________________ ID / Policy / Group # _______________ Insured's Name ______________

Secondary Insurance Carrier ________________ ID / Policy / Group # _______________ Insured's Name ______________

Vision Service Plan or VCP Comp Benefits or Eyemed

Member's Name ______________________________ Member's ID ____________________ Member's Birthdate ________

Member's Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Domestic Partner

Notices & Authorizations

1. Shared Medical Information Authorization
I authorize the Eyecare Center of Leesburg (ECoL) to share my medical records with the persons named below from the date signed until I provide the ECoL written notice to cease.
Emergency Contact: ______________________________ **P: (   )   -   .**
❑ Spouse __________________________ ❑ Friend __________________________
❑ Others: ____

Signature ____________________
Date ____________

2. Notice of Privacy Practices, HIPAA Acknowledgement (Copy given upon request)
I have read the Eyecare Center of Leesburg (ECoL) Notice of Privacy Practices and understand my rights contained therein. By way of my signature I acknowledge that the ECoL has provided me with a policy regarding the use and disclosure of my protected healthcare information for the purposes of treatment, and healthcare operations as described in the Notice of Privacy Practices.

Signature ____________________
Date ____________

3. Medicare Part B/Medigap Signature Authorization
I request that payment of authorized Medicare/Medigap benefits be made on my behalf to the Eyecare Center of Leesburg for any services furnished me by them. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Signature ____________________
Date ____________

4. Uncovered Services Authorization
I have been informed by the Eyecare Center of Leesburg that **Refraction, Lenses, Frames, Tints and Coatings** services will be denied by Medicare B as medically unnecessary or as services not covered by the Medicare Program. I agree to be personally and fully responsible for these services.

Signature ____________________
Date ____________

5. Email and Text Message Communications Authorization
As of the date signed I authorize the Eyecare Center of Leesburg (ECoL) to communicate information containing confidential personal health information via the provided email and/or mobile number provided on this form until my written notice to ECoL to cease. Further, I understand communication via email or text message is not encrypted and agree to waive any responsibility by the ECoL for any breach of information that may occur due to this authorization as well as any failure on my part to maintain the safety and security of access to such accounts authorized. Additionally, I agree to immediately notify the ECoL of any account changes or updates that may affect this authorization.

Specify authorized email/Text #
Email: ______________________
Texts to #: ____________________
(charges by your carrier may apply)

Signature ____________________
Date ____________

(Okay to estimate): Last Eye Exam __________ Last Physical Exam __________ **I am currently** ❑ Pregnant ❑ Nursing

Check ONE main reason for visit: ❑ Glasses/CL update ❑ Blurry vision ❑ Red eye/s ❑ Double vision ❑ Dry Eyes
❑ Flashes / Floaters ❑ Other ______________________________

Please complete and CHECK ALL THAT APPLY

1. Glasses — None ❑
My current glasses are... ❑ Prescription ❑ Prescription Sunglasses ❑ Computer ❑ Sports/specialty
I wear them… ❑ Full time ❑ Far only ❑ Near only ❑ Computer only ❑ As needed

2. Contact Lenses — None ❑
Name of current contacts: ______________________________
I wear them... ❑ None, but I am interested ❑ Full time ❑ Part time ❑ Monovision ❑ Discontinued

3. Visual demands
❑ Research ❑ Hair Stylist ❑ Mechanic work ❑ Farming ❑ Truck Driving ❑ Studying
❑ Card play ❑ Golfing ❑ Motorcycling ❑ Fishing ❑ Kayaking ❑ Outdoor exercise
❑ Cooking ❑ Equestrian ❑ Bicycling ❑ Shooting ❑ Other ________________
On an average day, I am on the computer / cell phone / tablet / etc.: ❑ < 2 hrs ❑ 2-6 hrs ❑ > 6 hrs

4. Family Medical History — None ❑
As far as I am aware, in my family (grandparents, parents, siblings, children) there has been…
❑ Glaucoma ❑ Keratoconus ❑ Night blindness ❑ Eye turn ❑ Macular degeneration ❑ Migraine
❑ Diabetes ❑ Hypertension ❑ Heart disease ❑ Cancer ❑ Other ________________

5. Personal Eye History
I have been diagnosed with… — None ❑
❑ Glaucoma ❑ Macular degeneration ❑ Eye turn ❑ Keratoconus ❑ Amblyopia ❑ Uveitis
❑ Trauma ❑ Diabetic Retinopathy ❑ Other: ______________________________

I have had surgery for: (include approximate date)
❑ Cataract Surgery RE ___/___/___, LE ___/___/___
❑ LASIK / Laser Surgery RE ___/___/___, LE ___/___/___
❑ Retinal Detachment Surgery RE ___/___/___, LE ___/___/___

6. Personal Medical History
I have been diagnosed with… — None ❑
Cardiovascular: ❑ High Cholesterol ❑ Hypertension ❑ Heart disease ❑ Heart attack / stroke
Respiratory: ❑ Sleep Apnea ❑ Asthma / COPD
Genitourinary: ❑ Kidney stones ❑ Kidney disease
Endocrine: ❑ Thyroid disorder ❑ Diabetes Type__, HbA1 ____% ___/___/___, FBS / RBS _____ mg/dl
Immunologic: ❑ Sjogren's ❑ Lupus
❑ Cancer: ______________________________
❑ Other Conditions: ______________________________
All Other Surgeries: ______________________________

7. Personal Review of Systems
I am currently experiencing the following symptoms.... — None ❑

Constitutional	❑ Unexplained fever / weight loss / fatigue
Cardiovascular	❑ Chest pain ❑ Irregular heartbeat ❑ Shortness of breath ❑ Hypertension
Ears/Nose/Throat	❑ Loss of smell ❑ Sinus congestion ❑ Hearing loss ❑ Sore throat / hoarse voice
Respiratory	❑ Shortness of breath ❑ Wheezing sounds ❑ Persistent cough
Gastrointestinal	❑ Vomiting blood / blood in stool ❑ Constipation / diarrhea
Genitourinary	❑ Difficulty / burning while urinating
Musculoskeletal	❑ Joint pain / restriction of motion ❑ Unexplained muscle pain / lower back pain
Immunologic/skin	❑ Unexplained rashes / itching ❑ Pigmented lesion ❑ History of infectious disease
Neurologic	❑ Weakness / tingling in extremities ❑ Dizziness/black/grey outs
Psychiatric	❑ Memory lapses ❑ Disorientation ❑ Ongoing depression ❑ Dementia
Endocrine	❑ Increased urination / thirst / appetite
Hematologic	❑ Anemia / frequent bruising
Lymphatic	❑ Swollen glands
Allergies	❑ Seasonal ❑ Penicillin ❑ Sulfa ❑Anesthetic ❑ Other ____________
Other	Any other current symptoms: ______________________________

8. Social History — None ❑
Do you smoke? ❑ Never ❑ Quit ______ (year quit) ❑ Yes | How much? ____ packs/day
Do you drink alcohol? ❑ Never ❑ rarely ❑ socially ❑ daily | What type? __________
Recreational drugs? ❑ Never ❑ rarely ❑ socially ❑ daily | What substance/s? ________

❑ I verify that all unchecked boxes in sections 1-8 are N/A.

10. SPEED: Dry Eye Questionnaire - Millions of people of all ages may suffer from Dry Eye Disease. We are concerned you may be suffering with this condition as well. Please take a few moments to complete this Standard Patient Evaluation of Eye Dryness (SPEED) questionnaire.

Circle the level of frequency and severity for each symptom	SYMPTOMS					Add frequency & severity totals. **Your dry eye level is:** 0-4 Mild, 5-7 Moderate, 8+ Severe
	Dry, gritty, or scratchy feeling	Soreness or irritation	Burning or watering	Eye fatigue	Fluctuating vision	
Frequency	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	Total frequency score: ______
Severity	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	Total severity score: ______

Circle Yes or No if you were symptomatic		
This Visit	**Yes**	**No**
W/in **last 72 hours**	**Yes**	**No**
W/in **last 3 Months**	**Yes**	**No**

Frequency Legend	**Severity Legend**
0 = Never	0 = No problems
1 = Sometimes	1 = Tolerable
2 = Often	2 = Bothersome
3 = Constant	3 = Irritating
	4 = Intolerable

Medications (Please include prescription & over the counter medications, eye drops, contraceptives & supplements)

❑ Please check here if you have brought your own attached list of medications

Name	Dose & SIG (How Often)	Purpose (Used for)

Allergies ❑ Please check here if you have brought your own attached list of allergies

I am allergic to…	My allergic reaction to this is….			
______________	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: ______________
______________	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: ______________
______________	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: ______________
______________	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: ______________
______________	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: ______________

How did you hear about us?

Check all that apply: ❑ Doctor referral ❑ Friend or family recommendation ❑ Social Media ❑ Online Search ❑ Other ___________