Today's Date: _____

1409 Washington Ave
Golden, CO 80401
303-271-1400

Demographic Information:

Legal Name: _____ **Preferred Name: _____**

Date of Birth: _____ Age: _____ **Preferred Contact Method:** Cell Home Email

Gender:
- ○ Male
- ○ Female
- ○ Other or Non-binary
- ○ Prefer not to answer

Sex (at birth):
Please circle
Male
Female

Pronouns: (select all that apply)
- ○ He/him
- ○ She/her
- ○ They/them
- ○ Other: _____

Race:
- ○ Caucasian descent
- ○ African descent
- ○ Native American
- ○ Asian descent
- ○ Native Hawaiian/Pacific Islander
- ○ Prefer not to answer

Ethnicity:
- ○ Hispanic
- ○ Non-Hispanic
- ○ Prefer not to answer

Cell Phone: _____

Home Phone: _____

Email Address:_____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

In case of emergency, please contact:

Name: _____

Cell: _____
Relation: Spouse Child/Parent Other

Employer: _____ **Occupation: _____**

Insurance Information

Name of Medical Insurance: _____

Primary's Information: **Same as above** □

Name: _____ Date of Birth: _____ Phone number: _____

Address: _____

We willingly accept payment on your behalf from most vision insurance plans. We will file your insurance claim for you whenever possible. We provide these additional services at no additional charge as a courtesy to our patients. If we will be filing an insurance claim for your visit or eyewear today, you must present proof of insurance *prior* to the initiation of services. We will always attempt to contact your insurance company to verify your eligibility and your benefit details prior to the initiation of services. Unfortunately, despite out best efforts, insurance companies cannot guarantee benefit information until they receive a bill. It is very important for you to understand that knowledge of your insurance eligibility and benefits is ultimately your responsibility and that you are ultimately responsible for all charges that you incur. It is our policy to have a copy of the insurance card so we may bill the insurance effectively. You are responsible for applicable co-payments and payment of your medical care within a reasonable time, regardless of billing status. Services not covered by your insurance are your responsibility.

Please check any of the following conditions by which you or a family member has been affected:		
Condition	**SELF**	**FAMILY**
Blindness		
Cataracts		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Head Injury		
High Blood Pressure		
Thyroid Disease		
Allergies		
Asthma		
Migraines		
Lazy/Turned Eye		
Autoimmune Disorder Which one?		
Ocular Migraines (if self) Frequency?		
Cancer What Kind? (if self) Treatment:		
Diabetes (if self) Primary Care Provider name and phone number:		
Other?		

Please indicate which of these applies to you:

Do you wear:

- Contacts?
  - Hard (scleral, RGP)
  - Soft (daily, monthly, unsure)
- Glasses?
- Both?
- Neither?

Please note that contact lens prescriptions require a contact lens exam. These exams are billed separately from the comprehensive exam and may or may not be covered by your insurance.

Have you had corrective surgery (PRK, Lasik, Cataract, etc)? If so, when? With whom?

At all of our appointments, we need to be able to view the back of your eye in order to check the health. We do this in two different ways that work together to give us the best view of your health. We have dilation, which gives us a 3D in depth view of the back of your eye, but will leave you with some light sensitivity and brief blurriness for up close reading vision. We also have our digital retinal exam. It takes a digital image that we are able to look back on year after year for comparison. **Our doctors recommend digital photos and dilation for all new patients.** Thereafter, for healthy individuals with no ocular abnormalities, the doctors recommend yearly photos and dilation every other year (at minimum).

Please choose

- Dilation
- Digital Retinal Exam (**additional $39 copay**)
- Both

Do you:

- Smoke
- Vape
- Drink Alcohol

If so, please indicate the frequency.

Are you currently taking any medication? Please include both prescription and over-the-counter, as well as the dosage and the reason.

Are you allergic to any medication? If so, please list.

Would you like a copy of our privacy policy? YES NO

Please notify us at any time if you have any special needs or restrictions regarding the standard use of your protected health information.

The above information is correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____