Welcome

PATIENT INFORMATION

Name: _____ Gender: ❑ Male ❑ Female

Address: _____ City: _____ State: _____ Zip: _____

Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____ Social Security Number: _____

Employer: _____ Occupation: _____

Check Appropriate Box: ❑ Single ❑ Married (Spouse) _____ ❑ Widowed ❑ Separated ❑ Divorced

Race: ❑ Asian ❑ Black / African American ❑ Hispanic ❑ White ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Native Hawaiian / Other Pacific Island ❑ Non Hispanic or Latino

Preferred Language: ❑ English ❑ Spanish

Communication Preferred: ❑ Email ❑ Phone ❑ Postage

Email Address: _____

RESPONSIBLE PARTY

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone ( ) _____

Employer: _____ SSN# _____ Work ( ) _____

* If we are a provider, we will file your health insurance for you, but you are ultimately responsible for payment. If we have not received payment from your insurance within 45 days, you will be billed for the balance due.

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN# _____ Name of Employer: _____ Work ( ) _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp #: _____ ID# _____

♦♦♦♦ DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING ♦♦♦♦

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN# _____ Name of Employer: _____ Work ( ) _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp #: _____ ID# _____

HIPPA PRIVACY NOTICE

I acknowledge that I received or was offered a copy of Family Vision Center's **Notice of Privacy Practices.**

Patient Name: _____ Signature **X** _____ Date: _____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE 2

HEALTH HISTORY

Reason for today's exam: _____

Date of last eye exam: _____ By Whom? _____

Interested in contacts or renewing contacts ❑ Yes ❑ No

EYE HISTORY: CHECK any of the following eye conditions or symptoms that apply to you.

❑ Blurred Vision	❑ Itching	❑ Light Flashes	❑ Cataract	❑ Macular Degeneration
❑ Red Eye	❑ Tearing	❑ Double Vision	❑ Cataract Surgery	❑ Amblyopia (Lazy Eye)
❑ Eye Pain	❑ Burning	❑ Light Sensitivity	❑ Glaucoma	❑ Retinal Detachment
❑ Eye Dryness	❑ Floaters	❑ Eye Injury	❑ Iritis	❑ Other _____

PERSONAL MEDICAL HISTORY: CHECK any health conditions that apply to you and list medication taken for it.

Health Problem	Medication	Health Problem	Medication
❑ Diabetes	_____	❑ Thyroid	_____
❑ Heart Problems	_____	❑ Headaches	_____
❑ High Blood Pressure	_____	❑ Migraines	_____
❑ High Cholesterol	_____	❑ Seizures	_____
❑ Stroke	_____	❑ Allergies	_____
❑ Cancer	_____	❑ Sinus	_____
❑ Arthritis	_____	❑ Dry throat/mouth	_____
❑ Lupus	_____	❑ Hearing Loss	_____
❑ Multiple Sclerosis	_____	❑ Memory Loss	_____
❑ Asthma	_____	❑ Insomnia	_____
❑ Emphysema	_____	❑ Depression	_____
❑ COPD	_____	❑ Alzheimer's	_____
❑ _____ (Other)	_____	❑ _____ (Other)	_____

Height: _____ Weight: _____ Are you pregnant or nursing? ❑ Yes ❑ No ❑ Does not apply

Are you allergic to any medications? ❑ Yes ❑ No Which _____

Who is your medical doctor? _____

SOCIAL HISTORY:

Tobacco use: ❑ Never Smoked ❑ Former Smoker ❑ Current Smoker Packs / day_____Years Smoking_____

Alcohol use: ❑ None ❑ Social use only ❑ 1-2 drinks daily ❑ Above average use ❑ Alcohol Dependant

FAMILY MEDICAL HISTORY: CHECK any family history for the following conditions.

Disease	Relationship	Disease	Relationship
❑ Glaucoma	_____	❑ Diabetes	_____
❑ Macular Degeneration	_____	❑ Cancer	_____
❑ Amblyopia (Lazy Eye)	_____	❑ Heart Attack	_____
❑ Blindness	_____	❑ Stroke	_____

A **dilated eye exam** is the national standard of care, important in detecting certain conditions and diseases of the retina which are more easily observed with dilation. Medicated eye drops dilate the pupil within 20 minutes, with usual recovery within 3 - 4 hours. While pupils are dilated, you will be sensitive to bright light and your near vision will not be as clear unless you are near-sighted or wearing bifocals. Most people are able to drive a car after dilation. Disposable sunglasses will be provided to help with the glare. If you desire not to have your eyes dilated, we will examine the retina without dilation.

Do you wish to have your eyes dilated today? ❑ Yes ❑ No ❑ Later ❑ Only if medically necessary