



Where Vision is Precious Beyond Measure

WELCOME TO OUR OFFICE

Mission Statement:

The doctors and staff of Family Vision Care are fully committed to exceeding your family's expectations of total eye health and vision wellness. We are dedicated to providing state-of-the-art eye care and the finest eyewear products available in an atmosphere of uncompromised service value and friendliness.

Our mission is to provide the most thorough and comprehensive eye care that will ensure you and your family a lifetime of comfort and the clearest of vision.

Patient Information	Patient Medical History
Last _____ First _____ MI _____ Salutation <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Sr. <input type="checkbox"/> Rev. <input type="checkbox"/> Jr. DOB _____ Age _____ Patient's Social Security Number _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Marital Status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/> Child Street _____ City _____ State _____ Zip Code _____ Home Phone _____ Cell Phone _____ Work _____ Email _____ ** You will receive a Patient Portal invite if there is an email on file** Employer(or School) _____ Occupation (or Grade) _____ Spouse (or Parent's Name) _____ Spouse (or Parent's Work) _____ Primary Language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other _____ Special Needs? <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Translator <input type="checkbox"/> Other _____ Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other _____ Ethnicity <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ Mother's Maiden Name _____ State of Birth _____	Primary Physician _____ City _____ Date of Last Physical _____ Date of Last Eye Exam _____ By Whom _____ Do you currently wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____ Solutions used _____ Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you prefer clear contacts lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No Pharmacy _____ Phone # _____ Do you see any specialists? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? _____ Who referred you to our office? _____ Current Medications (RX/Over the Counter) _____ Allergies to Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what? _____ Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes/tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Current drug user? <input type="checkbox"/> Yes <input type="checkbox"/> No Height _____ Weight _____ Reason for visit _____ When did symptoms start _____
Insurance Information	
<p style="text-align: center;">Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluations</p> Vision Insurance _____ Subscriber Name _____ Subscriber Social Security Number _____ Subscriber DOB _____ Primary Medical Insurance _____ Subscriber Name _____ Subscriber Social Security Number _____ Subscriber DOB _____ Do you participate in a flex spending account? <input type="checkbox"/> Yes <input type="checkbox"/> No How will you settle your account today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card	

Have you ever been diagnosed/treated for any of the following health problems? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Crossed Eye/Eye Turn |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eye Infections |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Flash of Light |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Digestive | <input type="checkbox"/> Eye Itchiness |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Eye Tearing |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Uncomfortable Glasses |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Eye Burning |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Integumentary (skin) | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Muscle/Bone | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Eye Grittiness |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Iritis/Ulveitis |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Changes in Weight | <input type="checkbox"/> Occasional Dry Eye |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Trouble seeing at night | <input type="checkbox"/> Other _____ |

Have you received the Flu Vaccine? Yes Date _____
 No

Have you received the Pneumonia Vaccine? Yes Date _____
 No

Family Medical History

Is there a family medical history of any of the following:
 Yes (Please check boxes below) No

	Relationship
	(Mother's/Father's side)
Blindness	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Stoke	<input type="checkbox"/> _____
Other	<input type="checkbox"/> If so, what? _____

Patient Authorization for Use and Disclosure of Protected Health Information

Phone Call and E-Mail Correspondence

I wish to be contacted at the following number(s):

I wish to be contacted at the following email(s):

You may leave a detailed message concerning my appointment or other details of my medical care or treatment

I give permission to have medical/appointments/billing information to be left on my:

Home Answering Machine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E-Mail	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HIPAA privacy rules give you the right to request a restriction of your PHI. When my information is used or disclosed pursuant to this authorization, it may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. ***Family Vision Care will not be liable for any emails sent to a non-encrypted location at your request or if an unauthorized person views the correspondence.***

By signing this authorization, you are providing us with permission to contact you by E-Mail. If you do not authorize us to communicate with you in the manner, please check "No."

- Yes
 No

Patient Name _____

Relationship _____

Signature _____

Date _____

This authorization will expire on: _____

****Please note, there is a \$50 No Show fee for appointments NOT canceled within 24 hours. There is a \$100 No Show fee for any testing NOT canceled within 24 hours.****

I certify that the above information is correct.

Patient Name (please print) _____

Relationship _____

Signature _____

Today's Date _____