Patient Information:

Patient Name ____

Birth Date ____________ Male Female

How may we help you: Exam Glasses Contacts Vision Therapy Other ___________________

Date of Last Eye Exam: ______________ Previous Optometrist: ____________________________________

Home Phone: _______________ Cell Phone: ________________ Email: ____________________
____

When is the best time to reach you? _____________________________

Mailing Address: ____
____

Has any member of your family been treated in our office? Yes No If yes, whom? ______________

How did you hear about our office? ____

Family Information:

Responsible Party or Insurance Holder self spouse mother father guardian

Name: ____ Policy holder Birthdate: ____________________

Policy holder last 4 of social security #________________________

Heath Insurance Company _______________________ Insurance Phone #________________________

Group # __________________________ Subscriber ID# ___________________________

Employer _______________________________

Vision Benefit Plan ____________________________________ Plan Phone #_____________________

Employer _______________________________

Ocular History: (please check all that apply)

Lazy Eye	Blurred vision at a distance	Blurred vision at near
Burning	Double Vision	Drooping Eyelids
Dryness	Eye pain and/or soreness	Floaters or spots
Fluctuating vision	Foreign body sensation	Halos around lights
Infection of eye or lid	Itching	Loss of peripheral vision
Loss of vision	Mucous discharge	Redness
Regular headaches	Sandy or gritty feeling	Sensitivity to light/glare
Strabismus (crossed eye)	Tired Eyes	Watery Eyes

Family History: (please check all that apply, first degree relatives only)

Blindness	Diabetes	Eye turn / lazy eye
Glaucoma	Hypertension	Macular degeneration

Medical History:

Are you under a physician's care now? Yes No Who? ____

Physician Phone: _____________________

What special accommodations may we provide for you? ____

Are you taking any medications or supplements, etc.? Please list ____________________________
____
____

Are you allergic to any medication? Please list ____

Do you currently drink alcohol? Yes No Approximately how much? __________________________

Do you currently smoke? Yes No Approximately how much? _______________________________

Have you smoked in the past? Yes No For how many mos/yrs? _____________________
____

Ethnicity: Hispanic Non-Hispanic Declined

Race: Caucasian African-American Native American Asian/Pacific Islander

Other:_____________ Declined

Women (please check if applicable) Pregnant Taking Oral Contraceptive

Have you had, or are you currently experiencing any of the following? (please check or circle all that apply and please describe where necessary)

Constitution. (Health in General) No Problems Lack of energy, unexplained weight changes, fever, jaw pain, cancer. Other, describe: ______________________________________

Ears, Nose, Mouth, & Throat No Problems Difficulty hearing, sinus problems, runny nose, sore throat, facial pain or numbness. Other, describe: ______________________________

C-V (Heart & Blood Vessels) No Problems Irregular heartbeat, chest pains, high cholesterol, high blood pressure. Other, describe: ______________________________

Respiratory (Lungs & Breathing) No Problems Shortness of breath, oxygen supplementation, sleep apnea, emphysema. Other, describe: ______________________________________

GI (Stomach & Intestines) No Problems Heartburn, constipation, diarrhea, nausea, vomiting, blood in stools. Other, describe: ______________________________________

GU (Kidney & Bladder) No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems. Other, describe: ______________________________

MS (Muscles, Bones, & Joints) No Problems Joint pain, muscle pain, arthritis, back pain. Other, describe: ____

Integumentary (Skin & Hair) No Problems Persistent rash, new skin lesion, change in existing skin lesion, acne, rosacea. Other, describe: ______________________________

Neurologic (Brain & Nerves) No Problems Frequent headaches, double vision, muscle weakness, dizziness, loss of consciousness, seizures. Other, describe:______________________

Psychiatric (Mood & Thinking) No Problems Insomnia, depression, anxiety, mood swings, hallucinations. Other, describe: ____

Endocrinologic (Glands) No Problems Diabetes, thyroid abnormalities, hormonal abnormalities. Other, describe: ____

Hematologic (Blood & Lymph) No Problems Easy bleeding, anemia, abnormal blood tests, leukemia. Other, describe: ____

Allergic/Immunologic No Problems Seasonal or environmental allergies, exposure to HIV, Hepatitis A,B,C. Other, describe: ______________________________________

Have you ever had any serious illness not disclosed above? Yes No Discuss: _____________
____
____

Emergency Contact: ________________________________Relationship to Patient: _____________________

Phone number: _____________________

To the best of my knowledge, all the preceding answers are correct.

Patient Signature (parent or guardian if under 18)____

Please report any changes to your medical history including change in medication, to our staff at your next appointment.

Authorization: I hereby authorize payment directly to Family Eye Care Center PLLC of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment and optical purchases. I hereby authorize Family Eye Care Center PLLC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care. The information on this page and the ocular/medical histories are correct to the best of my knowledge. I grant the right to the optometrist to release my ocular/medical histories and other information about my ocular/medical treatment to third party payers and/or other health professionals.

X____

Patient Father Mother Spouse Guardian

Acknowledgment of Notice of Privacy Practices:

Yes, I have read or had explained to me by this office the NNP & wish to continue my care under said terms.

No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.

Communication Opt –In: How would you like to receive appointment reminders/healthcare communications?

Home Phone Cell Phone Email Decline

For office use only:

The NPP could not be read due to the emergent nature of the care needed.

Communication barriers prohibited obtaining the acknowledgement.

Individual refused to sign.

Other (Please Specify) ____