# Welcome to Child & Family EyeCare Center

Reason for today's visit? ☐ Exam ☐ Glasses ☐ Contacts ☐ Vision Therapy Consult

Other _____

How did you hear about our office? (Referred by)_____

## Patient Information:

Name: _____ Date of birth: _____ ☐ Male ☐ Female

Address: _____(Apt#)_____

(City) _____ (State) _____ (Zip) _____

Phone:_____

Email: _____

Parent/Guardian Name: _____

Date of Last Eye Exam: _____ Previous Eye Care Provider: _____

Has your family or friends been treated in our office, or were you referred to us? ☐ Yes ☐ No

If yes, whom? _____

## Insurance Information:

**Responsible Party or Insurance Holder:** ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Guardian

Name: _____ Date of Birth: _____

Address: _____

**Heath Insurance Company** _____ Insurance Phone #_____

Group # _____Subscriber ID# _____

**Secondary Health Insurance Company**_____ Insurance Phone #_____

Group # _____Subscriber ID# _____

Employer _____

**Vision Benefit Plan** _____ Plan Phone #_____

Group # _____Last 4 of Social: _____ Subscriber ID# _____

## Vision History: (please check all that apply)

| | | |
|---|---|---|
| ☐ Amblyopia | ☐ 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: type 1 or 2 | ☐ Eye turn / lazy eye |
| ☐ Glaucoma | ☐ Hypertension | ☐ Macular degeneration |

## Medical History:

Are you under a physician's care now? ☐ Yes ☐ No If so, whom?_____

Physician Phone #: _____

What special accommodations may we provide for you? _____

Are you taking any medications, 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 months/years? _____

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 as 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, high blood pressure, chest pains, high cholesterol. 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

If yes, please explain: _____

In case of an emergency, please list:

Emergency Contact: _____

Phone number: _____

Relationship to Patient: _____

*Please keep us informed of any changes to your medical history, including changes in medication(s).*

**Authorization:** I hereby authorize payment directly to Family Eye Care Center PLLC of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment and optical purchases. In the event collection is required for past due invoices or accounts, the patient will be responsible for all expenses incurred, including, but not limited to collection costs, attorney fees, and court costs. 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_____ Date: _____

☐ 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.

**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.