Family Vision Associates

Eye Care for the Entire Family

www.familyvisiononline.com

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Date_____

Mr. Mrs. Ms. Miss. Dr.

Name_____

Address_____

City_____ State_____ Zip_____ SS#_____

Cell Phone_____ Home Phone_____

Date of Birth_____ Sex M ___ F ___ DL#_____ Age_____

Employer/School_____ Occupation/Grade_____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work Phone)_____

VISION/MEDICAL INSURANCE INFORMATION

Vision Insurance Yes ____ No ____

Insurance Name _____

Member Name _____

Member Date of Birth _____

Member SS# _____

Member Employer_____

The law requires that Family Vision Associates, L.L.P. make every effort to inform you of your rights related to your personal health information. By my signing below,

_____(Initial) I acknowledge that I have read or had explained to me Family Vision Associates, L.L.P.'s Notice of Privacy Practice and agree to continue my care under the said terms.

_____(Initial) I hereby certify the information provided is correct and true to the best of my knowledge.

_____(Initial) I hereby authorize payment of benefits directly to provider for services.

_____(Initial) I agree to pay any unpaid balances that my insurance does not pay.

_____

Patient's / Guardian's signature

Release of information

I hereby give authorization to Family Vision Associates LLP for release of my medical information to the following person(s):

( ) Spouse _____

( ) Child(ren) _____

( ) Parent _____

( ) Other _____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed _____ Date_____

OVER PLEASE

Date of Last Eye Exam_____

What is the major purpose of this visit?_____

Any problems with your present contact lenses or glasses? ❑ YES ❑ NO

Do you. . . . . .

Work at a computer for long periods? ❑ YES ❑ NO

Always like to wear your glasses? ❑ YES ❑ NO

Have prescription sunglasses? ❑ YES ❑ NO

Have problems with glare or reflection, particularly when driving at night? ❑ YES ❑ NO

Are you interested in contact lenses? ❑ YES ❑ NO

Have you worn before? ❑ YES ❑ NO

HEALTH HISTORY

Primary Care Physician_____

How would you describe your general health?

_____

Please check the corresponding box if you and/or a family member have any of the following:

	Yourself	Family Member
Arthritis	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Hay Fever	❑	❑
Heart Condition	❑	❑
High Blood Pressure	❑	❑
Migraine Headaches	❑	❑
Stroke	❑	❑
Thyroid Condition	❑	❑
Eye Disease / Blindness	❑	❑
Glaucoma	❑	❑
Eye Surgery	❑	
Eye Injuries	❑	
Eye Infections	❑	
Lazy Eye	❑	
Other_____	❑	

Tobacco use_____ Alcohol use_____

Allergies

List any allergies to medications or other substances.

_____

_____

_____

Medications

List any medications you are currently taking, including eyedrops.

_____

_____

_____

_____

_____

_____

_____

_____

How did you first hear about our office?

❑ Friend or Relative Who?_____

❑ Another Health Care Practitioner Who?_____

❑ Yellow Pages. . . . Which Directory?_____

❑ Other_____