

WELCOME TO FAMILY EYE HEALTH OPTOMETRY CENTER

Patient Information	Patient / Family Eye History																								
Last: _____ First : _____ Mid Initial: _____ Street: _____ City /State: _____ Zip Code: _____ HomePhone : _____ <input type="checkbox"/> Preferred Cell Phone: _____ <input type="checkbox"/> Preferred OK to text? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Birth _____ Age _____ Sex : M F Employer (or School): _____ Occupation (or Grade): _____ Spouse (or Parent's) Name: _____ Spouse (or Parent's)Work: _____ Email: _____ What is the major purpose of this visit? _____ _____ Date of Last Eye Exam: _____ Date of Last Dilation _____ By Whom? _____ Do you currently wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, What brand? _____ Solution: _____ Are you interest in being evaluated for contact lenses today?* <input type="checkbox"/> Yes <input type="checkbox"/> No Will you be using any Vision or Medical insurance coverage for your visit today? <input type="checkbox"/> Yes <input type="checkbox"/> No (Skip below) Vision Insurance: _____ Subscriber Name: _____ Subscriber DOB _____ Last 4 SSN: _____ Medical Insurance: _____ <input type="checkbox"/> HMO <input type="checkbox"/> PPO Will you be using flex spending today? <input type="checkbox"/> Yes <input type="checkbox"/> No NEW PATIENTS ONLY: Who may we thank for referring you to our office? <input type="checkbox"/> Friend/relative/ other DR: _____ If not referred, how did you choose our office? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Insurance List</td> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Google Search</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Saw Sign/Building</td> <td style="padding: 2px;"><input type="checkbox"/> Yellow Pages</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Yelp</td> <td style="padding: 2px;"><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Insurance List	<input type="checkbox"/> Google Search	<input type="checkbox"/> Saw Sign/Building	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Yelp	<input type="checkbox"/> Other _____	Are you experiencing any of the following symptoms? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Blurry Vision</td> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Itchiness</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Burning</td> <td style="padding: 2px;"><input type="checkbox"/> Grittiness</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Double Vision</td> <td style="padding: 2px;"><input type="checkbox"/> Sunlight Sensitivity</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Flash of light</td> <td style="padding: 2px;"><input type="checkbox"/> Tearing</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Floaters/Spots</td> <td style="padding: 2px;"><input type="checkbox"/> Trouble seeing at night</td> </tr> </table> Have you ever been diagnosed with any of the following? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Cataracts</td> <td style="width:50%; padding: 2px;"><input type="checkbox"/> Iritis/ Uveitis</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Corneal Abrasions</td> <td style="padding: 2px;"><input type="checkbox"/> Macular Degeneration</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Crossed eye/Lazy eye</td> <td style="padding: 2px;"><input type="checkbox"/> Retinal Detachment</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Glaucoma</td> <td style="padding: 2px;"><input type="checkbox"/> Other eye disorders</td> </tr> </table> Any Eye Injury/ Surgery/LASIK? _____ Family History of any eye conditions? _____ <div style="background-color: #cccccc; text-align: center; padding: 2px; font-weight: bold;">Patient Medical History</div> Name Of Physician: _____ Date of Last check Up: _____ CURRENT MEDICATIONS ((List name of medications including eye drops, vitamins, & birth control pills) : _____ _____ Do you use cigarettes/tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a medical marijuana card? <input type="checkbox"/> Yes <input type="checkbox"/> No Women Only- Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been diagnosed with any of the following: <input type="checkbox"/> Allergies; What kind? _____ <input type="checkbox"/> Cardiovascular (Arteriosclerosis, Heart murmur) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Constitutional (Fevers, Fatigue, Cough) <input type="checkbox"/> Head (Headaches, Sinusitis, Dry mouth) <input type="checkbox"/> Endocrine (Thyroid, Kidney) <input type="checkbox"/> Diabetes; Insulin/ Non-Insulin? _____ <input type="checkbox"/> Digestive (Acid Reflux, Cirrhosis, Colon/liver cancer) <input type="checkbox"/> Genitourinary (Prostate, Uterine, Kidney Stones) <input type="checkbox"/> Blood/Lymph (Anemia, Leukemia, Sickle cell) <input type="checkbox"/> Immunologic (AIDS, HIV, Herpes Simplex, Syphilis) <input type="checkbox"/> Skin (Acne, Basal Cell, dry skin, Psoriasis) <input type="checkbox"/> Muscle/Bone (Arthritis, Osteoporosis, Fibromyalgia) <input type="checkbox"/> Neurological (Bell's Palsy, MS, Epilepsy) <input type="checkbox"/> Psychological (Attn Deficit, Depression, Anxiety) <input type="checkbox"/> Respiratory (Asthma, Bronchitis, Lung Disease) Family History of any of the above conditions? _____ _____ _____	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Burning	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sunlight Sensitivity	<input type="checkbox"/> Flash of light	<input type="checkbox"/> Tearing	<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Iritis/ Uveitis	<input type="checkbox"/> Corneal Abrasions	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Crossed eye/Lazy eye	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other eye disorders
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Do/Are you.....(check box if your answer is yes) <input type="checkbox"/> ..want information on LASIK <input type="checkbox"/> ..work at a computer? How many hours? ____ day <input type="checkbox"/> .. spend time outdoors? How much? __ Hrs/wk <input type="checkbox"/> ..bothered with glare while driving at night? <input type="checkbox"/> ..have family members in need of eye care?																									

Cancellation/ No Show Policy

We understand that there are times when you may miss an appointment due to unexpected emergencies. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. If an appointment is not canceled at least 24 hours in advance, you will be charged a \$25 fee; this will not be covered by your insurance. I have read and understand the cancellation fee:

Signature X _____ Date _____

Refraction

A refraction is performed as part of your comprehensive eye examination, and involves measuring the type of degree of your refractive error to obtain an updated glasses prescription. If your eye glasses are purchased at our office, you have 90 days following your Comprehensive Eye Exam to return for a follow-up refraction at no charge. After 90 days, you will be charged \$45 for an updated glasses refraction if there are any problems with your glasses. If your glasses are purchased outside of our office, you may return within 30 days for a follow-up refraction at no charge. A Comprehensive Eye Examination and health evaluation is required after 6 months from your initial visit, as other health related factors can be contributing to changes in your prescription. The Glasses Prescription expires TWO YEARS from your last comprehensive eye exam. I have read and understand the Refraction fee:

Signature X _____ Date _____

*** Contact Lens Evaluation and Prescribing**

A Contact Lens Evaluation and Prescription is an additional service that involves measuring and prescribing the appropriate contact lens for your eye's individual needs. This service includes your trial lens and contact-lens related follow up visits for 60 days, in order to have the doctor check the contacts and ensure that you are not having any problems with the trial lenses. A Comprehensive Eye Exam is required within 6 months of obtaining a Contact Lens Evaluation and Prescription. This additional exam *may* be covered by your insurance as a benefit in lieu of glasses. Our fees are \$129 for a basic sphere lens; \$195 for toric (≤ -2.75), multi-focal, or monovision lens; \$250 for high toric (> -2.75) or combination lens; and \$700 for keratoconus fits. After 60 days, you will be charged \$59 for any additional contact lens related follow ups, and your trial period will be extended for an additional 60 days. The Contact Lens prescription expires after ONE YEAR. Upon expiration of your prescription, we are unable to sell any contact lenses without an updated prescription. I have read and understand the contact lens evaluation fee and acknowledge that I will receive a finalized copy of my prescription by email:

Signature X _____ Date _____

Advance Beneficiary Notice (For Patient's Using Insurance)

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If your insurance company has not reimbursed our office in full within 90 days, you will be billed for today's visit and your insurance company may then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. In the event that you are billed for your services and you do not make a reasonable effort to make payments, your account will be turned over to a collection agency. You would then be responsible for the full amount of your invoice from Family Eye Health Optometry Center, plus any fees incurred in the collection process.

Signature X _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Policies

Please be advised that a copy of our HIPAA policy is posted in our office, and a copy is available to all our patients. Please ask our staff if you would like a copy of our Privacy Policy today. By signing below, you acknowledge that a copy of Family Eye Health Optometry Center Notice of Privacy Practice was offered to you.

Signature X _____ Date _____