Welcome to Family & Pediatric Eye Care!

Patient's name: _____ Male/ Female Date of appointment: _____
First Last MI

Address: _____ City: _____ Zip: _____

Home phone: _____ Daytime phone: _____ Cell phone: _____

Patient's DOB: _____ Employer or School: _____ Occupation or Grade: _____

Spouse or Parent's name: _____ Emergency contact: _____

Whom may we thank for referring you to our office: _____

Insurance Information
***please fill in full social security number if we are billing insurance (vision and/or medical)**

Name of insurance company: _____ Member's name: _____

Member's contract number: _____ DOB: _____ Social Security number: _____

Name of employer: _____

Name of secondary insurance company: _____ Member's name: _____

Member's contract number: _____ DOB: _____ Social Security number: _____

Name of employer: _____

I certify that I, and/or my dependents have insurance coverage with the company stated above. I give permission to Family & Pediatric Eye Care to bill my insurance company and have payment made directly to their office. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize Family & Pediatric Eye Care to disclose such information to the above named insurance company for the purpose of obtaining payment for services and determining insurance benefits.

I understand that I am responsible for paying for all services at the time they are rendered. I agree to pay half down when I place my order and the remaining balance at the time I pick up my order.

Signature of responsible party: _____ Date: _____

Demand Force

We now have the ability to notify you of your order via text message and/or e-mail. Please take a moment to check the method that you prefer to be contacted. Please note: if you choose text and/or e-mail you can change your preferences anytime by simply choosing the preference updates link at the bottom of the initial e-mail you receive from us.

I prefer to be contacted via:

☐ text cell phone number: _____ ☐ phone telephone #: _____

☐ e-mail e-mail address: _____ ☐ postcard address: _____

Notice of Patient Privacy
***we have a full copy of the Notice of Privacy Practices form upon request**

I acknowledge that I understand the Notice of Privacy Practices for Family & Pediatric Eye Care. Date: _____

Signature: _____ Name of patient: _____

Reason for your visit to our office today
***please check all that apply**

☐ poor distance vision	☐ poor near vision	☐ floaters or spots	☐ eye infection	☐ eye turn
☐ double vision	☐ eye injury	☐ sensitivity to light	☐ dry eyes	☐ eye strain
☐ eyes burn/itch/water	☐ lazy eye	☐ need contacts	☐ need glasses	☐ annual eye exam

Do you currently wear glasses? _____ If so, how often? _____

Do you currently wear contacts? _____ If so, what type? _____ Are you interested in being fit for contacts? _____

Do you currently wear sunglasses? _____ Are you interested in sunglasses? _____

When was your last eye examination? _____ Previous Doctor: _____

Medical History
***please check all that apply**

Self

- ☐ Diabetes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cancer
- ☐ Headaches
- ☐ Ear/Nose/Throat
- ☐ Nervous System
- ☐ Skin
- ☐ Genitourinary
- ☐ Pregnant
- ☐ Mental condition
- ☐ Allergies (hay fever)
- ☐ Allergies to medications
- ☐ Surgeries
- ☐ Thyroid
- ☐ Heart Condition
- ☐ High blood pressure
- ☐ Turned or lazy eye
- ☐ Asthma/Respiratory Condition
- ☐ Gastrointestinal
- ☐ Cardiovascular
- ☐ Endocrine (glands)
- ☐ Musculoskeletal
- ☐ Blood/Immunologic
- ☐ Given birth in past 6 months
- ☐ Developmental/learning condition

Family

- ☐ Diabetes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cancer
- ☐ Thyroid
- ☐ Heart Condition
- ☐ High blood pressure
- ☐ Turned or lazy eye
- ☐ Macular degeneration

If yes, please list: _____

If yes, what type & when surgery was performed: _____

_____

Please list any medications you are taking, including vitamins and supplements: _____

_____

Personal/Social History

Do you smoke?	☐ No	☐ Yes	How much? _____
Do you drink alcohol?	☐ No	☐ Yes	How much? _____
Do you use other substances?	☐ No	☐ Yes	How much? _____
Do you have any hobbies?	☐ No	☐ Yes	Please list: _____
Do you drive?	☐ No	☐ Yes	Any visual difficulties: _____

Welcome to Family & Pediatric Eye Care, we are looking forward to being your eye care provider. If there is anything we can do to make your experience at our office more enjoyable, please make our office staff aware.

Thank you!