Welcome to FAMILY EYE CARE CENTER

CLEAR VISION BEGINS WITH HEALTHY EYES

Patient Information

Thank your for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name _____ Date _____
Dr./Master/Miss/Mr./Mrs./Ms. First MI Last
Address _____
City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____ Work Phone _____
Do you prefer to receive calls at: [ ] Cell [ ] Home [ ] Work Do you text? [ ] Yes [ ] No
Date of Birth _____ Age _____ Social Security # _____
Email Address _____ Are You? [ ] Minor [ ] Married [ ] Widowed [ ] Single [ ] Partnered
Your Employer _____ Occupation _____
If You are a Student, Name of School/College _____ City _____ State _____
Spouse's/Partner's Name _____ Workplace _____
Spouse's/Partner's Work Phone _____ Spouse's/Partner's Social Security # _____
Spouse's Date of Birth _____ Minor Children's Names _____
Would you like to set up appointments for any family members? [ ] Yes [ ] No
Person to contact in case of an emergency _____ Phone _____
Whom may we thank for referring you to us? _____
If you were not referred, how did you hear about our office? _____

Responsible Party

(If Different From Patient)
Name of person responsible for this account? _____
Relationship to patient _____ Phone _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Social Security # _____
Name of Employer _____ Phone _____

Insurance Information

Name of Vision Insurance _____ Member's ID _____
Name of Medical Insurance _____ Member's ID _____

Retinal Photography is an enhanced level of service that is NOT covered by all insurance companies. However, Dr. Reid highly recommends retinal photography for ALL his patients. Retinal Photography provides specialized documentation of the internal eye health for future reference and, in most cases but not in all cases, your medical insurance company will be billed for this procedure. If the insurance does not pay, you may be billed $49 or the insurance carriers allowable amount , in the event the deductible has not been met.

PLEASE TURN FORM OVER AND CONTINUE ON OTHER SIDE...

Welcome to FAMILY EYE CARE CENTER

Health History

Reason for Today's Exam _____

_____

Date of Last Eye Exam _____ Name of Eye Doctor _____

Date of Last Physical Exam _____ Name of Medical Doctor _____

Do you or anyone in your immediate family have a history of any of the following eye symptoms or problems?

[ ] Diabetes [ ] Blindness [ ] High Blood Pressure [ ] Arthritis [ ] Stroke

[ ] Cataracts [ ] Thyroid [ ] Turned or Lazy Eye [ ] Lupus [ ] Macular Degeneration

[ ] Glaucoma [ ] Heart Condition [ ] Respiratory Problems [ ] Cancer

Please Check any of the following conditions that apply to you:

[ ] Frequent Headaches [ ] Allergies [ ] Sinus Trouble [ ] Have given birth in last six months

[ ] Head Injury [ ] Drug Allergies [ ] Pregnant [ ] HIV+

Please List all prescription and OTC medications, vitamins, or supplements you are currently taking _____

_____

_____

Please List any medications you are allergic to _____

Do you use tobacco products? [ ] Yes [ ] No If yes [ ] occasional [ ] 1/2 pack/day [ ] 1 pack/day [ ] 1+pack/day

Have you ever had any of the following conditions involving your eyes?

[ ] Eye Surgery [ ] Sensitivity to Light [ ] Eye Infection or Disease [ ] Difficulty Driving at Night

[ ] Eye Injury [ ] Floaters or Spots [ ] Double Vision [ ] Retinal Detachment

[ ] Medical Treatment [ ] Poor Distance Vision [ ] Eye Strain [ ] Transient Loss of Vision

[ ] Severe Pain [ ] Poor Near Vision [ ] Eyes Burn, Itch or Water [ ] Dry Eyes

Do you currently wear glasses? [ ] Yes [ ] No

[ ] All the Time [ ] Reading/Near Work Only [ ] Other, Please explain _____

[ ] Safety at Work [ ] Distance Tasks Only

[ ] Computer Work [ ] Sports

Have you ever worn contact lenses? [ ] Yes [ ] No

Are you interested in wearing contact lenses? [ ] Yes [ ] No

If yes, what style?

[ ] Soft [ ] Extended Wear [ ] Gas Permeable [ ] Bifocal

[ ] Tinted [ ] Astigmatic [ ] Disposable [ ] Unsure

Do you work at a computer or video display terminal? [ ] Yes [ ] No

If yes, do you use specific PRIO/Computer Glasses? [ ] Yes [ ] No

Are you interested in Laser Vision Correction? [ ] Yes [ ] No

What hobbies or sports do you participate in? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or healthcare practitioner. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE