

FAMILY VISION CLINIC

PATIENT INFORMATION

Last Name: _____
 First Name _____ MI _____
 Address: _____
 City _____ State _____ ZIP _____
 (H) _____ (W) _____
 (C) _____ DOB _____
 Email _____
 May we use your email for in office announcements? _____
 Employer _____
 Date of last eye exam _____ Dilated? Y/N
 Today's date _____
 Emergency contact _____ (P) _____
 How did you hear about us? _____
 Insurance Newspaper Yellow Pages Friend Other

INSURANCE INFORMATION

Who is responsible for this account? _____
 Relationship to patient? _____
 Insurance Company _____
 ID Number _____
 Subscribers Name _____ DOB _____
 Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to the Family Vision Clinic all insurance benefits, if any, otherwise payable to me for services rendered. **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. The Family Vision Clinic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and the agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date Relationship to Patient

EYE HEALTH HISTORY

Please mark Yes or NO if you have/had any of the following.

Blurred Vision-Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurred Vision-Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crossed eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharge from eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye surgery or injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Itchy eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Light sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Red eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flashes of light	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Watery eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Twitchy eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Floater or spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor night vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type _____	Hours/Day _____	
Describe any problems you have with your contacts _____		

HEALTH HISTORY

Physician's Name _____
 Date of Last Visit _____

Do you have problems with any of these systems? Mark Yes or No.

Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears/Nose/Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscles/bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Integumentary (skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endocrine (glands)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood/lymph	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergic/immunologic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Health Problems: _____

MEDICATIONS

List any medications you are currently taking, including eye drops: _____

ALLERGIES

List your allergies to medications or environmental: _____

FAMILY HEALTH HISTORY

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other		

Reviewed By: _____	Date: _____	Reviewed By: _____	Date: _____
Reviewed By: _____	Date: _____	Reviewed By: _____	Date: _____
Reviewed By: _____	Date: _____	Reviewed By: _____	Date: _____