

Family EyeCare Center -- Welcome to Our Office!

PERSONAL INFORMATION

NAME (LAST)		(FIRST)	(MIDDLE)	NICKNAME	DATE OF BIRTH
AGE	SEX	HOME ADDRESS		CITY, STATE, ZIP CODE	HOME PHONE #
EMPLOYER/SCHOOL NAME		EMPLOYER/SCHOOL ADDRESS		CITY, STATE, ZIP CODE	WORK PHONE #
SOCIAL SECURITY		MARRIED [] SINGLE []	EMAIL ADDRESS		CELL PHONE #
DATE OF LAST EYE EXAM		PREVIOUS EYE DOCTOR			
DATE OF LAST MEDICAL EXAM		PRIMARY CARE PHYSICIAN			
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE					
EMERGENCY CONTACT			RELATIONSHIP	CONTACT #	

SPOUSE/PARENT/GUARDIAN INFORMATION

SPOUSE/PARENT/GUARDIAN	ADDRESS (IF DIFFERENT)	CITY, STATE, ZIP CODE	HOME/CELL PHONE #
EMPLOYER	EMPLOYER ADDRESS	CITY, STATE, ZIP CODE	WORK PHONE #

INSURANCE INFORMATION

MEDICAL INSURANCE		ID#	
POLICYHOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
POLICYHOLDER'S EMPLOYER & ADDRESS			POLICYHOLDER'S WORK#
VISION INSURANCE		ID#	
POLICY HOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
WORKER'S COMP CLAIM?	EMPLOYER ADDRESS	CONTACT PERSON	PHONE #

SPECIAL PERMISSIONS

Please initial and date applicable statements below:

I give Family EyeCare Center permission to leave voicemail/answering machine messages at my home, cell, or email	INITIAL	DATE
I give Family EyeCare Center permission to discuss my medical care/billing with:		
Name: _____ Relationship: _____	_____	_____
Name: _____ Relationship: _____	_____	_____
I have received a notice of privacy practices.....	_____	_____
Include me on Family EyeCare Center mailings? [] Yes [] No		

In the event my deductible has not been met, or my insurance company does not pay in full or denies payment, I understand that I or the person responsible for the account will be required to pay the balance.

There is an additional charge for contact lens part of our exam. Most insurance companies do not cover contact lens related office visits, so I understand the additional charge will be my responsibility.

I authorize payment of insurance benefits be made to the office of Family EyeCare Center for any services or materials furnished. I authorize this office and the above insurance companies to release pertinent information so the benefits payable may be determined for the services and/or materials provided.

Signature _____ Date _____

Thank you for choosing Family EyeCare Center for your vision needs!
(see reverse)

Family EyeCare Center

SOCIAL HISTORY

(Required to document according to federal guidelines)

Height: _____ feet _____ inches	Weight: _____ lbs.
Do you use tobacco products? [] No [] Yes	If Yes, type: _____ amount: _____ how long: _____
Do you drink alcohol? [] No [] Yes	If Yes, type: _____ amount: _____ how long: _____
Do you use illegal drugs? [] No [] Yes	If Yes, type: _____ amount: _____ how long: _____
Are you pregnant and / or nursing? [] No [] Yes	
Have you ever been exposed to or infected with: [] Gonorrhea [] Hepatitis [] HIV [] Syphilis	Other: _____

VISUAL LIFESTYLE SURVEY

Occupation: _____	
Favorite Leisure Activities: _____	
About how many hours a week do you spend:	
At a computer? _____	Outdoors? _____
Driving during the daytime? _____	Driving during the nighttime? _____
Playing sports? _____	Reading? _____
Watching TV? _____	
If you wear glasses today, is there anything you don't like about them? _____	
Do you have a useable spare pair of eyewear? _____	
Do you currently wear sunglasses? _____	
Are you interested in contact lenses? _____	