**Where Vision is Precious Beyond Measure**

# WELCOME TO OUR OFFICE

Mission Statement:
The doctors and staff of Family Vision Care are fully committed to exceeding your family's expectations of total eye health and vision wellness. We are dedicated to providing state-of-the-art eye care and the finest eyewear products available in an atmosphere of uncompromised service value and friendliness.

Our mission is to provide the most thorough and comprehensive eye services that will ensure you and your family a lifetime of comfort and the clearest of vision.

## Patient Information

Last ______________________________
First ______________________ MI __________
Salutation ❑ Mr. ❑ Mrs. ❑ Miss. ❑ Ms. ❑ Dr. ❑ Sr. ❑ Rev. ❑ Jr.
DOB ______________________ Age __________
Patient's Social Security Number ______________
Gender: ❑ Male ❑ Female ❑ Other
Marital Status? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner ❑ Child
Street ______________________________
City ______________________ State __________
Zip Code ______________________________
Home Phone ______________________________
Cell Phone ______________________________
Work ______________________________
Email ______________________________
** You will receive a Patient Portal invite if there is an email on file**

Primary Language? ❑ English ❑ Spanish ❑ French ❑ German ❑ Other __________
Special Needs? ❑ Wheelchair ❑ Hearing Impaired ❑ Translator ❑ Other
Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ White ❑ Native Hawaiian/Other Pacific Islander ❑ Other __________
Ethnicity ❑ Not Hispanic/Latino ❑ Hispanic/Latino ❑ Unknown ❑ Other __________
Mother's Maiden Name ______________________
State of Birth ______________________

## Insurance Information

***Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluations***

Vision Insurance ______________________
Subscriber Name ______________________
Subscriber Social Security Number ______________
Subscriber DOB ______________________

Do you participate in a flex spending account? ❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

## Patient Medical History

Primary Physician ______________________
City ______________________
Date of Last Physical ______________________

Date of Last Eye Exam ______________________
By Whom ______________________

Do you currently wear contacts? ❑ Yes ❑ No
If yes, what kind? ______________________
______________________
Solutions used ______________________
______________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Pharmacy ______________ Phone # ______________

Do you see any specialists? ❑ Yes ❑ No
If so, who? ______________________

Who referred you to our office? ______________________

**Current Medications (RX/Over the Counter)** ______________
______________________
______________________

Allergies to Medications? ❑ Yes ❑ No
If so, what? ______________________
______________________

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco? ❑ Yes ❑ No
Do you drink alcohol? ❑ Yes ❑ No
Current drug user? ❑ Yes ❑ No

Height ______________ Weight ______________

Continued on Backside----->

**Have you ever been diagnosed/treated for any of the following health problems?** *(check all that apply)*

| | |
|---|---|
| ❑ Allergies | ❑ Blurry Vision |
| ❑ Arthritis | ❑ Cataracts |
| ❑ Blood/Lymph | ❑ Crossed Eye/Eye Turn |
| ❑ Cancer | ❑ Eye Infections |
| ❑ Cholesterol | ❑ Flash of Light |
| ❑ Diabetes | ❑ Glaucoma |
| ❑ Digestive | ❑ Eye Itchiness |
| ❑ Ears/Nose/Throat | ❑ Macular Degeneration |
| ❑ Endocrine | ❑ Retinal Detachment |
| ❑ Fatigue | ❑ Eye Tearing |
| ❑ Fevers | ❑ Uncomfortable Glasses |
| ❑ Genitourinary | ❑ Eye Burning |
| ❑ High Blood Pressure | ❑ Corneal Abrasions |
| ❑ Integumentary (skin) | ❑ Double Vision |
| ❑ Kidney | ❑ Eye Injury |
| ❑ Muscle/Bone | ❑ Floaters/Spots |
| ❑ Neurological | ❑ Eye Grittiness |
| ❑ Psychological | ❑ Iritis/Ulveitis |
| ❑ Respiratory | ❑ Lazy Eye |
| ❑ Changes in Weight | ❑ Occasional Dry Eye |
| ❑ Headaches | ❑ Sunlight Sensitivity |
| ❑ Trouble seeing at night | ❑ Other____________________ |

_____________________________________________________
_____________________________________________________

Have you received the COVID-19 Vaccine? ❑ Yes Date_______
❑ No

Have you received the Flu Vaccine? ❑ Yes Date__________
❑ No

Have you received the Pneumonia Vaccine? ❑ Yes Date_______
❑ No

## Family Medical History

Is there a family medical history of any of the following:

❑ Yes (Please check boxes below) ❑ No

| | Relationship (Mother's/Father's side) |
|---|---|
| Blindness | ❑ ____________________ |
| Cancer | ❑ ____________________ |
| Cataracts | ❑ ____________________ |
| Corneal Problems | ❑ ____________________ |
| Diabetes | ❑ ____________________ |
| Glaucoma | ❑ ____________________ |
| Heart Disease | ❑ ____________________ |
| Lazy Eye | ❑ ____________________ |
| Macular Degeneration | ❑ ____________________ |
| Retinal Problems | ❑ ____________________ |
| Stoke | ❑ ____________________ |
| Other | ❑ If so, what?______________ |

_____________________________________________________

## Patient Authorization for Use and Disclosure of Protected Health Information

***Phone Call and E-Mail Correspondence***

I wish to be contacted at the following number(s):

_____________________________________________________
_____________________________________________________

I wish to be contacted at the following email(s):

_____________________________________________________
_____________________________________________________

You may leave a detailed message concerning my appointment or other details of my medical care or treatment

**I give permission to have medical/appointments/billing information to be left on my:**

| | | |
|---|---|---|
| Home Answering Machine | ❑Yes | ❑No |
| Cell Phone | ❑Yes | ❑No |
| Work Phone | ❑Yes | ❑No |
| E-Mail | ❑Yes | ❑No |

HIPAA privacy rules give you the right to request a restriction of your PHI. When my information is used or disclosed pursuant to this authorization, it may be subjected to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. ***Family Vision Care will not be liable for any emails sent to a non-encrypted location at your request or if an unauthorized person views the correspondence.***

By signing this authorization, you are providing us with permission to contact you by E-Mail. If you do not authorize us to communicate with you in the manner, please check "No."

❑ Yes
❑ No

Patient Name_________________________________________

Relationship_________________________________________

Signature___________________________________________

Date_______________________________________________

**By signing you certify that the information on this form is correct.**