WELCOME TO FAMILY VISION CENTER

Mr. Mrs. Ms. Dr. Last Name	First Name Middle Initial	Date of Birth	Today's Date
Address	City	State	Zip Code
Email Address Can we use email for promos? Y or N	Cell Phone	Home Phone	Work Phone

Sex: M F	Social Security Number of Patient	If minor, parent/guardian's name: Parent/guardian's social security number: Parent/guardian's date of birth:

GENERAL HEALTH			
	You		In Family
Diabetes			
High Blood Pressure			
Rheumatoid Arthritis			
Lupus			
Thyroid Problems			
Neurological			
Cholesterol Other:			

EYE HISTORY			
	You		In Family
Glaucoma			
Cataract			
Eye Injury			
Lazy Eye			
Eye Surgery			
Dry Eyes			
Other:			

CURRENT VISUAL PROBLEMS		
	With glasses	Without glasses
Blur at distance		
Blur at near		
Headaches		
Seeing spots or lights		
Eyes burn, itch, or tear		
Seeing double		
Other:		

Please list all current medications you are taking including eye drops:

_____

List anything you are allergic to, including medications: _____

Do you smoke? ___Yes ___No Do you have an alcohol/substance abuse problem? ___Yes ___No

Your primary care physician: _____ City/State: _____

When was your last eye exam? _____ Where? _____

Have you ever worn contact lenses? ____Type? _____Are you interested in contact lenses today? ___

INSURANCE CARRIER _____ Member #: _____

Insured's Name: _____Relationship to patient: _____Insured's Date of Birth:_____

OFFICE INFORMATION ☐ For NEW patients only—please check box for a copy of our Notice of Privacy Practice.

I hereby authorize any necessary treatment by the doctors in the practice of Family Vision Center and agree to be responsible for my bill and any collection fees for non-payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims or obtain any medical/vision information from my attending physician or medical facility. I am aware that a Notice of Privacy Practice is available for me to see and/or a copy will be made available upon request.

Patient's/Guardian's Signature: _____ Date: _____

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