

WELCOME TO FAMILY VISION CENTER

Mr. Last Name Mrs. Ms. Dr.	First Name	Middle Initial	Date of Birth	Today's Date
Address	City	State	Zip Code	
Place of Employment/Occupation	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:		

Email Address: _____

GENERAL HEALTH			
	Yes	No	In Family
Diabetes			
Hypertension			
Heart Problems			
Asthma			
Thyroid Problems			
Arthritis			
Other: _____			

EYE HISTORY			
	Yes	No	In Family
Glaucoma			
Cataract			
Eye Injury			
Lazy Eye			
Eye Surgery			
Eye infection			
Other: _____			

CURRENT VISUAL PROBLEMS		
	Yes	No
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: _____ 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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