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Family Vision Care

Eaton
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Telephone (937) 472-5665
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PATIENT INFORMATION

Date _____

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ SS# _____ Age _____ SEX: M F
MISS MS. MRS. MR. DR. (PLEASE CIRCLE)

Home Address _____ City _____ State ____ Zip _____

Birthdate _____ Home phone # _____ Work phone # _____

Cell Phone # _____ Email: _____

Your or your parent's employer _____ Occupation _____

Business Address _____ City _____ State ____ Zip _____

If you are a student, name of school/college _____ Grade _____ City _____ State _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Name of employer _____ Work phone # _____

INSURANCE INFORMATION

Name of insured _____ Birthdate _____ Relationship to patient _____

Social Security # _____ Name of employer _____ Insurance Co. _____

DO YOU HAVE ADDITIONAL INSURANCE? ❒ No ❒ Yes IF YES, PLEASE COMPLETE THE FOLLOWING

Name of insured _____ Birthdate _____ Relationship to patient _____

Social Security # _____ Name of employer _____ Insurance Co. _____

INSURANCE INFORMATION

Please circle payment choice: Cash Check VISA MasterCard Discover Vision Care Insurance Other (Please Specify)

Full payment due upon completion of services.
For your convenience, we accept VISA, Mastercard, and Discover.
Accounts 30 days past due subject to a rebilling fee of 2.0% (min. $2.00) per month.

As a courtesy, we will bill your vision care insurance for you. However, we are not responsible for collecting your claim or negotiating settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy.

I authorize the optometrist to release any information acquired in the course of examination or treatment for insurance purposes. I acknowledge that I am responsible for non-covered services. I authorize and request my insurance company to pay directly to the optometrist insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian _____ Date _____

(Continued on Reverse Side)

Revised 7/10

Health & Vision History

Reason for today's exam_____

Date of last eye exam_____ Name of eye doctor_____

Date of last physical_____ Name of doctor_____

What is your general health?_____

Does anyone in your immediate family have a history of the following?

- ☐ Diabetes Relation_____
- ☐ High blood pressure Relation_____
- ☐ Cataracts Relation_____
- ☐ Blindness Relation_____
- ☐ Glaucoma Relation_____
- ☐ Heart condition Relation_____
- ☐ Thyroid difficulty Relation_____
- ☐ Turned or lazy eye Relation_____
- ☐ Macular Degeneration Relation_____
- ☐ Retinal Detachment Relation_____
- ☐ Other_____

Do you have problems with any of these systems?

- ☐ Eyes
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Integumentary (skin)
- ☐ Mental
- ☐ Nervous
- ☐ Blood/lymph
- ☐ Diabetes
- ☐ Ear/Nose/Throat
- ☐ Endocrine (glands)
- ☐ Allergic/immunological

Please Explain_____

Please check any of the following conditions that apply to you:

- ☐ Diabetes Type_____ Date of Diagnosis_____
- ☐ Allergies To what?_____ What happens?_____
- ☐ Medication Allergy To what?_____ What happens?_____
- ☐ Frequent headaches ☐ Pregnant ☐ Sinus trouble
- ☐ Other health problems_____
- ☐ Current medications(including over the counter and birth control):_____
- ☐ Have you had any operations? Kind?_____ When?_____
- ☐ Do you use cigarettes/tobacco?_____ Alcohol?_____ Other Substance?_____
- ☐ Date of last tetanus shot_____

Have you ever had any of the following conditions involving your eyes?

- ☐ Eye surgery Type_____ Date_____
- ☐ Eye injury Type_____ Date_____
- ☐ Sensitivity to light
- ☐ Floaters or spots
- ☐ Poor distance vision
- ☐ Poor near vision
- ☐ Eye infection or disease
- ☐ Double Vision
- ☐ Sandy, dry or gritty eyes
- ☐ Other eye problems_____
- ☐ Eye strain
- ☐ Eye fatigue
- ☐ Itching eyes
- ☐ Medical treatment
- ☐ Severe pain
- ☐ Burning eyes

Do you currently wear glasses? ☐ Yes ☐ No If YES, When do you wear your glasses?

- ☐ All the time
- ☐ Distance tasks only
- ☐ Reading/near work
- ☐ Other_____
- ☐ Computer work
- ☐ Work safety

Have you ever worn contact lenses? ☐ Yes ☐ No

If so: Where were you fitted?_____ Date of initial fitting_____

Type of contact lenses?_____ Wearing schedule? daily extended

Type of solutions used?_____

Do you have any problems at all with your contacts?_____

If you quit wearing them, Why?_____

In what hobbies or sports do you participate?_____

Do you work at a computer or video display terminal? ☐ Yes ☐ No Type of Computer_____