Family Eye Care, P.C.

Patient Information

Last Name: _____ **First Name:** _____ **M:** _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Phone:(H)_____(C)_____(W)_____

Birthday:____/____/____ **Sex:** M /F **SS #:**_____ **Email:**_____

Marital Status: Single Married Divorced Separated Widowed

Work Status: Full Time Part Time Self Employed Retired **Student:** F/T P/T

Household:

Financially Responsible Person: _____ **Birthday:** ____/____/____

Address: _____ **City:** _____ **St:** _____ **Zip**_____

Relationship to Patient:_____ **SS #**_____

Vision Insurance:_____ **ID #**_____

Medical Insurance:_____ **ID #**_____ **Group #**_____

Is patient covered under more than one vision plan? Y/N **If yes what:**_____

Member Name:_____ **Employer**_____

We are happy to submit your insurance claim, however you are responsible for full amount if no response from insurance in 60 days.

All deductibles, co-payments or non-covered services or materials are due at time of service.

I acknowledge the notification of the Practice's Privacy Policy, and I understand that I have the right to obtain a copy of this Privacy Notice.

Signature of Patient or Guardian_____ **Date**_____

Medical Questionnaire

Date: _____

Name: _____ Primary Medical Dr.: _____

Last Eye Exam: _____ Where: _____

Do You Wear Glasses: Y/N Contacts? Y/N How Old Are They? _____

If Yes To Contacts, What Type? _____ How Often Replaced? _____

Have You Ever Had Eye Surgery? Y/N For What? _____ When? _____

Where? _____

Review of Symptoms

Have You Experienced Any Of The Following?

Sandy/Gritty/Foreign Body Sensations	Y/N	Blurred Vision	Y/N
Flashes Of Light and/or Floaters	Y/N	Double Vision	Y/N
Itching/Burning/Stinging Eye	Y/N	Severe or Frequent Headaches	Y/N
Redness/Dryness	Y/N	Blackout or Temp Loss of Vision	Y/N

Eye infections? Y/N What? _____

Eye Injury? Y/N How? _____

Do you or any blood relatives have any of the following health problems in the following areas:

Diabetes	Y/N	Self/Family Relationship _____
High Blood Pressure	Y/N	Self/Family Relationship _____
Heart Disease	Y/N	Self/Family Relationship _____
Cancer	Y/N	Self/Family Relationship _____
Lupus	Y/N	Self/Family Relationship _____
Arthritis	Y/N	Self/Family Relationship _____
Thyroid Disease	Y/N	Self/Family Relationship _____
Glaucoma	Y/N	Self/Family Relationship _____
Lazy, Crossed Eye/s	Y/N	Self/Family Relationship _____
Macula Degeneration	Y/N	Self/Family Relationship _____
Blindness	Y/N	Self/Family Relationship _____
Fever/Weight Gain/Loss	Y/N	Self/Family Relationship _____
Lung Problems	Y/N	Self/Family Relationship _____
Integumentary(skin)	Y/N	Self/Family Relationship _____
Ear/Nose/Throat/Mouth	Y/N	Self/Family Relationship _____
Gastrointestinal (diarrhea/constipation)	Y/N	Self/Family Relationship _____
Lymphatic/Hematologic(Anemia)	Y/N	Self/Family Relationship _____
Allergies(seasonal,food, etc.)	Y/N	Self/Family Relationship _____
Neurological(headaches, etc.)	Y/N	Self/Family Relationship _____
Psychological	Y/N	Self/Family Relationship _____
Other	Y/N	Self/Family Relationship _____

List any medications(including over the counter): _____

_____

List any allergies to medications: _____

Do You Smoke? Y/N Do You Drink Alcohol? Y/N Do You Use Illegal Drugs? Y/N

Are You Pregnant? Y/N How Far Along? _____

Have You Ever Been Exposed or Infected with a Venereal Disease? Y/N What? _____

Do you have problems with night driving? Y/N

Do you use a computer? Y/N If yes, how many hours a day? _____