

Welcome to Advanced Family Eyecare

Adult Form (Please Print)

Date ____/____/____

Social Security # ____ - ____ - ____

Name _____

Gender: M F Date of Birth ____/____/____

Address _____

***Referred by _____

City _____ State _____ Zip _____

Spouse Name _____

Home phone (____) _____ - _____

Spouse Social Security # ____ - ____ - ____

Work phone (____) _____ - _____

Spouse Date of Birth ____/____/____

Cell phone (____) _____ - _____

Spouse Work phone (____) _____ - _____

Employer _____

Spouse Cell phone (____) _____ - _____

Occupation _____

Spouse's Employer _____

E-mail Address _____

Emergency Contact _____

Date of last eye exam _____

Phone # (____) _____ - _____

Who performed last eye exam? _____

Relationship _____

Insurance Information

Vision Insurance _____

To better serve you, all insurance claims will be processed **immediately** with the insurance information provided at the time of the appointment.

Primary Member _____

Primary Member ID _____

Primary Member Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY & ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical and/or surgical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not they are paid by my insurance.** I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims.

AUTHORIZED SIGNATURE _____

DATE _____

Personal & Family Medical History

	None	Self	Family	Relationship		None	Self	Family	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nerve Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skeletal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Medications (Rx & Over-the-Counter)

Antihistamines: _____

Blood Pressure Meds: _____

Cholesterol Meds: _____

Diabetic Meds: _____

Eye Drops: _____

Oral Contraceptives: _____

Other Medications: _____

Allergies to Medications: _____

Primary Care Physician: _____

Social History

Do you smoke? Yes No

If yes: occasionally 1-2 packs/wk

3-4 packs/wk 1+ packs/day

Do you drink alcohol? Yes No

If yes: occasionally 1/day 2-3/day 4+/day

Reviewed: Date: _____ Patient Initials: _____ Doctor: _____
Date: _____ Patient Initials: _____ Doctor: _____
Date: _____ Patient Initials: _____ Doctor: _____
Date: _____ Patient Initials: _____ Doctor: _____

PATIENT:

Auto-refraction

staple here

Optomap

Patient Spec Rx

DATE:

	Sph.	Cyl.	Axis	Add	Prism	Vertex
OD						
OS						

Contacts:

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