

# Welcome to Advanced Family Eyecare

Child Form (Please Print)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Name \_\_\_\_\_

Gender: M F

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

\*\*\*Referred by \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Who performed last eye exam? \_\_\_\_\_

Father \_\_\_\_\_

Mother \_\_\_\_\_

Father's Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Mother's Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Father's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mother's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Father's Employer \_\_\_\_\_

Mother's Employer \_\_\_\_\_

Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who is responsible for payment? Father Mother Other \_\_\_\_\_

## 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: \_\_\_\_\_ Guardian Initials: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Date: \_\_\_\_\_ Guardian Initials: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Date: \_\_\_\_\_ Guardian Initials: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Date: \_\_\_\_\_ Guardian Initials: \_\_\_\_\_ Doctor: \_\_\_\_\_

PATIENT:

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**Auto-refraction**

staple here

**Optomap**

**Patient Spec Rx**

DATE:

	Sph.	Cyl.	Axis	Add	Prism	Vertex
<b>OD</b>						
<b>OS</b>						

Contacts:

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Contacts:

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