FAYETTE FAMILY VISION CARE

Patient Name:_____

Child Patient Parent's Name(s):_____

Street/Mailing Address:_____

City:_____State:_____Zip:_____ *Circle one* Male / Female

Home Phone:(____)_____Cell Phone: (____)_____

E-mail Address:_____Okay to ☐ *email* ☐ *text* appt reminders/order notifications

Date of Birth:_____Social Security Number:_____

Employer/School:_____Work Phone:(____)_____

Emergency Contact:_____Emergency Contact Phone: (____)_____

Date of Last Eye Exam:_____Previous Eye Doctor:_____

What is the primary reason for your visit today?_____

*Please check if you are having any of the following **eye** problems*:

☐ Poor vision	☐ Itching/burning	☐ Dryness
☐ Eye pain/soreness	☐ Gritty feeling	☐ Discharge
☐ Tearing	☐ Glare/light sensitivity	☐ Tired eyes
☐ Redness	☐ Double vision	☐ Flashes/floaters

Do you currently wear Glasses?_____Contact Lenses?_____Type of CL:_____

Hobbies/Sports:_____

How did you find out about our office? _____

Please initial the following:

_____**Consent for Care**: I hereby give consent for treatment to FFVC.

_____**Polycarbonate Lenses**: Polycarbonate lenses are the most impact resistant lenses available. They are strongly recommended for patients with compromised vision in one eye, patients who are active in sports, patients who work with power tools, and patients under the age of 18.

_____**Authorization to Leave Message**: I hereby authorize FFVC to leave a message regarding pending appointments, tests, glasses, or contact lenses at the numbers given.

_____**Acknowledgement of Receipt of Notice of Privacy**: I have been given the opportunity to read the Notice of Privacy Practices as required by HIPAA Privacy Regulations.

_____**Insurance Authorization/Payment Guarantee**: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits. I authorize payment of medical benefits to the physician or supplier of services.

I agree that I am solely responsible for all charges related to my visit. I understand that I am responsible for any and all balances due after insurance payments have been applied. I understand that I am responsible for all fees and legal expense related to collection of my balance. I understand there is a $35.00 return check fee.

Signature of Patient/Guardian:_____Date:_____