FAYETTE FAMILY VISION CARE

Patient Name:_____

If Child, 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 Lenses:_____

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. **All eyeglass sales are final.**

Signature of Patient/Guardian:_____Date:_____

FAYETTE FAMILY VISION CARE

Patient Name:_____ Date:_____

List any **medications** you take (Prescription, Over the Counter, Eye Drops, Birth Control, etc): ☐ NONE_____

List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc) or **injuries** (concussion, trauma, etc.): ☐ NONE

List any **surgeries** you have had (eye, heart, appendix, knee, etc): ☐ NONE_____

List any medications you are **allergic** to: ☐ NONE_____

Please check if you **currently** have problems in the following areas and provide additional information below.

General/Constitution ☐ NONE ☐ fever ☐ weight loss/gain ☐ unusually tired ☐ other
Ears/Nose/Throat ☐ NONE ☐ hard of hearing ☐ ear ache ☐ cough ☐ sore throat ☐ dry mouth ☐ stuffy nose ☐ other
Cardiovascular ☐ NONE ☐ high blood pressure ☐ racing pulse ☐ heart attack ☐ chest pain ☐ stroke ☐ other
Respiratory ☐ NONE ☐ congestion ☐ wheezing ☐ asthma ☐ shortness of breath ☐ bronchitis ☐ emphysema ☐ other
Gastrointestinal ☐ NONE ☐ upset stomach ☐ diarrhea ☐ constipation ☐ hernia ☐ ulcers ☐ heart burn ☐ other
Genital/Kidney/Bladder ☐ NONE ☐ painful/freq urination ☐ kidney disease ☐ prostate disease ☐ STD ☐ other
Muscles/Bones/Joints ☐ NONE ☐ joint pain ☐ stiffness ☐ swelling ☐ cramps ☐ arthritis ☐ other
Allergic/Immunological ☐ NONE ☐ sneezing ☐ swelling ☐ redness ☐ itching ☐ hives ☐ HIV/AIDS ☐ Lupus ☐ other
Blood/Lymph ☐ NONE ☐ bleeding ☐ high cholesterol ☐ anemia ☐ other
Neurological ☐ NONE ☐ numbness ☐ headache ☐ seizures ☐ paralysis ☐ other
Skin ☐ NONE ☐ acne ☐ growths ☐ rash ☐ other **Psychiatric**☐NONE ☐ anxiety ☐ depression ☐ insomnia ☐other
Endocrine ☐ NONE ☐ Diabetes ☐ hypothyroid ☐ other **Females** ☐ NONE ☐ pregnant ☐ nursing

Explain all checks:_____

DIABETIC Patients: What year were you diagnosed with Diabetes?_____ What was your last blood sugar reading?_____

Date of Last Medical Exam:_____ Name of Primary Care Physician: _____

*Please check if **you** have ever been diagnosed with any of the following eye problems?* ☐ NONE

☐ Cataracts ☐ Iritis/Uveitis ☐ Retinal/Macular/Corneal Disease
☐ Glaucoma ☐ Dry Eyes ☐ Lazy Eye

Explain checks/OTHER:_____

Please check if your mother, father, sister, brother, daughter or son has/had any of these diseases? ☐ NONE

☐ Blindness ☐ Diabetes ☐ Cancer
☐ Cataracts ☐ High Blood Pressure ☐ Thyroid Disease
☐ Glaucoma ☐ Retinal/Macular/Corneal Disease

Explain checks/OTHER:_____

Does your vision limit any activities of daily living such as driving, reading, work, or sports? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If yes, How Much?_____

Do you smoke? ☐ YES ☐ NO If yes, How Much?_____ How long?_____

Physician Initials/Date: _____ _____ _____