****

**Personal Information**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_\_\_ Date\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ / 20\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Marital Status: **Single Married Widowed Divorced Separated**

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Method of Contact: Phone \_\_\_\_\_ Email \_\_\_\_\_Text \_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Gender  **M F**

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: [ ]  Family/Friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Internet [ ]  Insurance [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient History**

Date of Last Eye Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Eye Doctor/Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Name/Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle if you have ever had any of the following:

Cataracts – Glaucoma – Macular Degeneration – Eye Injury – Lazy Eye – Eye Surgery

Do you Smoke? Y or N Amount\_\_\_\_\_\_\_\_\_\_\_ Use Alcohol? Y or N Amount\_\_\_\_\_\_\_\_\_\_\_ Recreational Drugs Y or N

Women: Are you pregnant or nursing? Y or N

**Eye History Yes No Medical History Yes No Yes No**

Blurred Vision [ ] [ ]  High Blood Pressure [ ] [ ]  Ulcers [ ] [ ]

Itching [ ] [ ]  Stroke [ ] [ ]  Asthma [ ] [ ]

Burning [ ] [ ]  Heart Disease [ ] [ ]  Hearing Loss [ ] [ ]

Tearing [ ] [ ]  Cholesterol [ ] [ ]  AIDS or HIV [ ] [ ]

Flashes of Light [ ] [ ]  Cancer [ ] [ ]  Multiple Sclerosis [ ] [ ]

Floaters [ ] [ ]  Arthritis [ ] [ ]  **Family History Who**

Double Vision [ ] [ ]  Seizures [ ] [ ]  Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Strain [ ] [ ]  Anemia [ ] [ ]  Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Vision [ ] [ ]  Diabetes [ ] [ ]  Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headaches [ ] [ ]  Thyroid [ ] [ ]  Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking (**we can take a copy of pre-written lists**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN OFFERED A PRIVACY POLICY BY FAMILY VISION CARE, PS AND I ALSO GRANT PERMISSION FOR FAMILY VISION CARE, PS TO BILL MY INSURANCE COMPANY ON MY BEHALF. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND THAT I AM RESPONSIBLE FOR ANY FEES THAT ARE NOT COVERED AND WILL PAY THE BALANCE IN FULL.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE (Parent or legal guardian if under 18) DATE