Office Use Only:	Date:
Date:	Date:
Date:	Date:

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 _____
Member _____
Member ID_____
Member Date of Birth _____

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

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND 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 and Family Medical History

	N/A	Self	Family	Relationship		N/A	Self	Family	Relationship
Allergies	□	□	□	_____	Cataracts	□	□	□	_____
Asthma	□	□	□	_____	Glaucoma	□	□	□	_____
Arthritis	□	□	□	_____	Macular Degeneration	□	□	□	_____
Cancer	□	□	□	_____	Eye Injury	□	□	□	_____
Heart Disease	□	□	□	_____	Eye Surgery	□	□	□	_____
High Cholesterol	□	□	□	_____	Blindness	□	□	□	_____
High BP	□	□	□	_____	Diabetes	□	□	□	_____
Headaches	□	□	□	_____	Skin Disorder	□	□	□	_____
Kidney Problems	□	□	□	_____	Anxiety	□	□	□	_____
Nerve Problems	□	□	□	_____	Depression	□	□	□	_____

Current Medications
(Rx & Over-the-Counter)

Antihistamines _____
Diuretics (water pills) _____
Blood Pressure Meds _____
Oral Contraceptives_____
Sleeping Tablets _____
Eye Drops _____
Allergies to Medications_____
Other _____

Are you currently under the care of a physician? Yes No

Name of physician _____

Social History

Do you smoke? Yes No

If yes: occasionally 1 pack/day

2-3 packs/day 4+packs/day

Do you drink alcohol? Yes No

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

Pediatric Physician: _____