Welcome to Advanced Family Eyecare

Adult Form (Please Print)

Date_____/_____/_____

Name_____

Address _____

City _____ State_____ Zip_____

Home phone (_____) _____-_____

Work phone (_____) _____-_____

Cell phone (_____) _____-_____

Employer _____

Occupation _____

E-mail Address _____

Date of last eye exam _____

Who performed last eye exam? _____

Social Security #_____-_____-_____

Gender: M F **Date of Birth**_____/_____/_____

*****Referred by** _____

Spouse Name _____

Spouse Social Security #_____-_____-_____

Spouse Date of Birth_____/_____/_____

Spouse Work phone (_____) _____-_____

Spouse Cell phone (_____) _____-_____

Spouse's Employer _____

Emergency Contact _____

Phone # (_____) _____-_____

Relationship _____

Insurance Information

Vision Insurance _____
Primary Member _____
Medical Insurance _____
Primary Member_____

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_____

Current Medications
(Rx & Over-the-Counter)

Allergy Meds _____
Blood Pressure Meds _____
Cholesterol Meds _____
Oral Contraceptives _____
Diabetic Meds _____
Eye Drops _____
Other Meds & over-the-counter Meds _____
_____
Allergies To Medications _____

Social History

Do you smoke? Yes No
Are you a former smoker? Yes: Year quit____ No

If yes: Occasionally 1-2pack/wk
3-4 packs/wk 1+ packs/day

Do you drink alcohol? Yes No

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

Are you currently under the care of a physician? Yes___ No___
Name of physician_____Address_____ Phone #_____

Personal and Family Medical History

Eye Conditions:	N/A	Self (please list condition)	Family	Relationship
Glaucoma	☐	☐ _____	☐	_____
Macular Degeneration	☐	☐ _____	☐	_____
Cataracts	☐	☐ _____	☐	_____
Eye Injury	☐	☐ _____	☐	_____
Eye Surgery	☐	☐ _____	☐	_____
Blindness	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____

Personal and Family Medical History

	N/A	Self (please list condition)	Family	Relationship
Ear/Nose/Throat:				
Hay Fever	☐	☐ _____	☐	_____
Sinus Congestion	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Cardiovascular:				
Heart Disease	☐	☐ _____	☐	_____
High Blood pressure	☐	☐ _____	☐	_____
High Cholesterol	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Respiratory:				
Asthma	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Gastrointestinal				
Irritable Bowel	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Genitourinary:				
Kidney Problems	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Musculoskeletal:				
Arthritis	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Integumentary:				
Skin Disorder	☐	☐ _____	☐	_____
Neurological:				
Headaches	☐	☐ _____	☐	_____
Migraines	☐	☐ _____	☐	_____
Seizures	☐	☐ _____	☐	_____
Stroke	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Psychiatric:				
Anxiety	☐	☐ _____	☐	_____
Depression	☐	☐ _____	☐	_____
Alzheimer's/Dementia	☐	☐ _____	☐	_____
ADD/ADHD	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Endocrine:				
Diabetes	☐	☐ _____	☐	_____
Thyroid Disease	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Lymphatic:				
Anemia	☐	☐ _____	☐	_____
Bleeding Problems	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
Allergies:				
Seasonal	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____
General:				
Cancer (type and date Dx)	☐	☐ _____	☐	_____
Other	☐	☐ _____	☐	_____

Reviewed: **Date:**_____ **Patient Initials:**_____ **Doctor:**_____
Date:_____ **Patient Initials:**_____ **Doctor:**_____
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Date:_____ **Patient Initials:**_____ **Doctor:**_____