Medical History

Name_____ Today's Date_____
Address_____ Date of Birth_____
City / Zip_____ Occupation_____
Phone_____ Hobbies_____
Email_____ Employer_____

Name of Primary Medical Doctor_____
Last Medical Exam_____ Last Eye Exam_____

What is your reason for today's eye exam? Please mark all that apply

____ Blur at Distance	____ Red Eyes	____ Eye pain/Discomfort
____ Blur at Near	____ Flashes/Spots	____ Itching/Allergies
____ Computer Strain	____ Glaucoma	____ Contact Lenses
____ Double Vision	____ Headache	____ Other

Have you had any eye injuries? __No __Yes Please explain:_____
Have you had any eye surgeries? __No __Yes Please explain:_____
How old are your current glasses? _____
How old are your current contact lenses? _____
Are you interested in information on laser eye surgery? __No __Yes

Medical History
Do you have, or have you been treated for:

___ Diabetes	___ Arthritis/Joint Pain	___ Breathing Problems
___ High Blood Pressure	___ Kidney/Urinary	___ Depression/Anxiety
___ Heart Disease	___ MS	___ Sinus/Allergy
___ Stroke	___ Cancer	___ Skin Condition
___ Stomach Problems	___ STD	___ Dry Eyes
___ Hearing Loss	___ Thyroid/Glands	___ Styes/Chalazion
___ Weight Loss/Gain	___ Double Vision	___ Headache/Migraines
___ Eye Pain/Itching	___ Loss of Vision	___ Other

Do you take any medications? __No __Yes If yes, please list:_____
_____
Do you have any allergies? __No __Yes If yes, please explain: _____
Are you now pregnant? __No __Yes
Do you smoke? __No __Yes How much?_____
Do you drink alcohol? __No __Yes How much?_____
Do you have a history of recreational drug use? __No __Yes

Do you have any parents/grandparents with any of the following medical conditions?

_____Diabetes	_____Glaucoma
_____High Blood Pressure	_____Macular degeneration

Insurance Information - Please present your insurance cards before exam

Insurance Provider: Aetna, BCBS, Davis-Vision, Medica, Medicare, VSP Other:_____
Policy Holder's Name_____
Policy Holder's DOB_____

Decline of Insurance

I have chosen the Private-Pay option and decline insurance submission.

_____ _____
Signature of patient or guardian of minor Date

Method of Payment

_____Cash _____Check _____Visa _____Mastercard _____Discover
* Full payment must be made at the time of visit.

- I understand that I am financially responsible for payment of any services provided by Advanced Family Eyecare, including services not covered by my insurance, as well as co-pays, deductibles and co-insurance.
- I request that payment of authorized insurance benefits, including Medicare, be made to Advanced Family Eyecare for services furnished to me by any provider employed by this clinic.
- I authorize Advanced Family Eyecare to release any medical information to other providers who are involved in my treatment.
- This authorization and assignment will remain in effect until revoked by me in writing

X_____ _____
Signature of patient or guardian of minor Date

Acknowledgement of HIPAA Privacy Act

I acknowledge that I've received a copy of Advanced Family Eyecare Notice of Policy Practices.

X_____ _____
Signature of patient or guardian of minor Date