Family Vision & Eye Care, P.A.

Name____**Date**__________________________________
Address________________________________ **Prefix:** Mr. Ms. Mrs. Miss Dr. Master
City____ **Suffix:** Jr. Sr. II III IV
State__________**Zip**_____________________ **Eye Doctor**_________________________
Birthdate______/_____/______ **Family Doctor**______________________
Social Security#__________/_____/________ **Specialty Doctor**____________________

(Please Circle)

Marital Status: single married divorced **Employment:** Employed Retired Other
Gender: male female Full-time Student Part-time Student
Race*: White Native American Asian African American Hawaiian/Pac Islander No Answer
Ethnicity*: Hispanic/Latino No Answer Non-Hispanic
Preferred Language*: English Spanish American Sign Language No Answer Other
*Asked as required under provisions of the American Recovery and Reinvestment Act

Home Phone (___)_____-________ **Work Phone (___)_______-_________ Ext**________
Cell (___)_________-_________Email (will never be shared)____________________________
Vision Plan____
Medical Insurance____
Patient Employer/School__________________________________**Occup/Grade**_______________
Address____**Phone**______________________

I authorize release of any medical information necessary to process insurance claims.
I authorize payment of benefits either to myself or to Family Vision & Eye Care, PA.
I acknowledge that I have been given opportunity to receive the Notice of Privacy Practices.
Signed______________________________________**Date**________________________________

Head of Household Information (if different than patient)
Name____**Social Security#**______/____/___________
Relationship to patient____________________________**Birthdate**_______/_____/_______
Employer________________________________**Address**______________________________________

Husband/Wife____________________________________**Social Security#**______/____/__________
Employer________________________________**Address**______________________________________

Person to Contact in Emergency_____________________________**Phone**______________________

(OVER PLEASE)

Name ______________________________ ☐ All answers "None" except as noted

Allergic/Immun. ☐None
- ☐ drug allergy
- ☐ environmental allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐

Notes:

Eyes ☐ None
- ☐ glaucoma
- ☐ cataract
- ☐ macular degeneration
- ☐ surgery
- ☐ inflammatory disorders
- ☐ blurred vision
- ☐ double vision
- ☐

Notes:

Musculoskeletal ☐None
- ☐ fibromyalgia
- ☐ muscular dystrophy
- ☐ osteoarthritis
- ☐ ankylosing spondylitis
- ☐

Notes:

Cardiovascular ☐None
- ☐ heart disease
- ☐ high blood pressure
- ☐ stroke
- ☐ vascular disease
- ☐

Notes:

Gastrointestinal ☐None
- ☐ Chrohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive
- ☐

Notes:

Neurological ☐None
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ Altzheimer's
- ☐ Parkinson's
- ☐ cerebrovascular
- ☐

Notes:

Constitutional ☐None
- ☐ developmental disability
- ☐ weight loss
- ☐ fever
- ☐ fatigue
- ☐ trauma
- ☐

Notes:

Genitourinary ☐None
- ☐ STD-viral herpetic, chlamydia
- ☐

Notes:

Psychiatric ☐None
- ☐ depression
- ☐ panic disorder
- ☐ schizophrenia
- ☐

Notes:

Ears, Nose & Throat ☐None
- ☐ upper resp. tract infection
- ☐ ringing-tinitis
- ☐ ear ache
- ☐ runny nose
- ☐ sore throat
- ☐

Notes:

Hematologic/Lymp ☐None
- ☐ anemia
- ☐ large volume blood loss
- ☐ leukemia
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐

Notes:

Smoking status:
- ☐ Daily smoker
- ☐ Some daysmoker
- ☐ Former smoker
- ☐ Never smoker

Respiratory ☐None
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐

Endocrine ☐None
- ☐ non-insulin dependent diabetes
- ☐ insulin dependent diabetes
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction

Diabetic since:
Last A1c result:

Integumentary ☐None
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐

Notes:

Medications / Reason
- ☐ None

Family History
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Hypertension
- ☐ Diabetes