Flowood Family Vision

Patient Information

Last name_____ First_____ Middle_____

Address_____ City_____ St_____ ZIP_____

Preferred Name_____ M___ F____ Social #_____

DOB_____ Age _____ Occupation_____(Ex: student, accountant)

Parent/guardian name (if under 18) _____

Cell phone#_____ Alternate phone#_____

Email Address: _____

Are you: Single Married Widowed Divorced

Do you wear glasses _____contacts_____ both_____

If not, are you interested in wearing contact lenses? Yes_____ No_____ Not today_____

Please give all insurance cards to the receptionist, **if you do not have a card fill out below:**

Name of vision insurance: _____ ID#_____

Name of medical insurance_____ ID_____

I do not have any insurance _____

I have read and understand the Notice of Privacy Policy (located on clipboard)

Signature_____ Self Date_____

_____parent/guardian if under 18 Date_____

Insurance Signature on file- Please read and sign if we will be billing your insurance company:

I authorize the release of any medical information necessary to process my insurance claim for services rendered by Dr. Chris White DBA as Flowood Family Vision. I also authorize payment of any benefit from my insurance company to Dr. White for services rendered. I understand that if my insurance company does not pay this fee, that I am responsible for these charges and agree to pay within 30 days of being notified or make financial arrangements as necessary.

Signature_____ Date_____

Parent (if under 18) _____ Date_____

Medical History

Name: _____ **Occupation** _____
Date of Birth ____/____/_____ **Phone Number:** _____ **Date:** ____/____/2023

Eye History

When was your last eye exam? **(If not here)** _____

Do you ever experience any of the following symptoms?

☐Blurred Vision ☐Contact Lens Discomfort ☐Foreign body sensation
☐Headaches ☐Mucous discharge ☐Floaters or spots in vision
☐Itchy Eyes ☐Burning ☐Tired Eyes/Eye Fatigue
☐Dry Eyes ☐ Light Sensitivity ☐Vision Fluctuations
☐Watery Eyes ☐Redness ☐Eye irritation and/or pain
☐Scratchy, feeling of sand or grit ☐Other_____

Eye Conditions, Injuries, or Surgery

☐Cataracts ☐Glaucoma ☐Macular Degeneration ☐Diabetic Retinopathy
☐Eye Allergies ☐Dry Eye Syndrome ☐Retinal Detachment ☐Corneal Ulcer
☐Cataract Surgery ☐Lasik ☐Lazy Eye, Other _____

Primary Care Physician: _____ **Phone #**_____

Medical History: Please check any of the following medical conditions that **you** have:
☐Diabetes ☐Thyroid ☐High Blood Pressure ☐Heart Disease ☐Arthritis ☐Headaches
☐Seizures ☐Cancer ☐Stroke ☐High Cholesterol ☐Anxiety ☐Depression ☐Allergies
☐Lupus ☐Sarcoidosis ☐Sjogren's ☐Hepatitis ☐Histoplasmosis ☐Rosacea
☐Bell's Palsy ☐Parkinson's ☐Asthma ☐COPD ☐Pregnancy or Nursing ☐HIV/AIDS
☐Other medical conditions: _____

Please list any medications you are taking (or provide list)

_____

Please list all drug allergies you have:

_____

Family history.
Have any members of your immediate family had any of the following conditions? (Check all that apply) ☐Cataract, ☐Glaucoma, ☐Macular Degeneration, ☐Lazy Eye, ☐Diabetes, ☐Stroke ☐Heart Disease, ☐Thyroid Disease, ☐Other_____

Social History
Do you drink alcohol? Yes / No if yes, how much? ☐Social ☐Daily ☐Alcohol Dependence
Do you smoke? Yes / No if yes, how much? ☐ Occasional ☐ Everyday

History reviewed by: _____ *Date* ____/____/2023 *(Doctor's initials)*