Welcome to Advanced Family Eyecare

Child Form (Please Print)

Date______/______/______

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

Name ____________________________________

Email Address ____________________________________

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 ____________________________
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:**____________________

Date:________________ **Patient Initials:**____________ **Doctor:**____________________

Date:________________ **Patient Initials:**____________ **Doctor:**____________________

PATIENT:

Auto-refraction

staple here

Optomap

Patient Spec Rx

DATE:

	Sph.	Cyl.	Axis	Add	Prism	Vertex
OD						
OS						

Contacts:

DATE:

	Sph.	Cyl.	Axis	Add	Prism	Vertex
OD						
OS						

Contacts:

DATE:

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OD						
OS						

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OD						
OS						

Contacts: