Patient Information **Today's Date / /**

First:	MI:	Last:	DOB: / /
			SSN: - -

Address:		Patient Status		
City:		☐ Single	☐ Married	☐ Other
State:	Zip	**Employment Status**		
Home#		☐ Full Time	☐ Part Time	
Work#		☐ Not Employed	☐ Retired	
Cell#		☐ Full Time Student	☐ Part Time Student	
		Relationship to Insured		
Email:		☐ Self ☐ Spouse	☐ Child	☐ Other

Name of Vision Insurance : (circle one) VSP Eyemed VBA VCP Spectera (Other_____________)

Primary Member Name	
Primary Member SSN#	Primary DOB

Medical/Health Insurance (not your vision insurance)

Insurance Co. Name		Member ID/Card #		
Insured Name		Group#		
DOB: / /	SSN: / /	Employer's Name:		
Address:		Current Occupation:		
City:		Is there another health benefit plan for eye care?	☐ Yes	☐ No
State:	Zip:			
		If yes please list the Plan Name:		

How did you hear about us? ____.

Attention:
Please remember that verification and/or pre-certification is not a promise of payment from your insurance company. The patient is still responsible for payment of the bill. However, we will submit a claim for services to your primary insurance carrier on your behalf. Any claims denied will default the balance to the patient.

****

Privacy Practices Acknowledgement

I have received the notice of privacy practices and I have been provided an opportunity to review it.

____ _______________

Patient Name Birth Date

____ _______________

Parent or legal guardian signature Date

Family Vision Center

Evagelos Agapios, O.D.
3002 Horizon Rd.
Rockwall, TX 75032

Patient History and Information

Patient Name: **Today's Date** / /

Visual History

When was your Last Eye Exam? ………………………………………… ______/______/______
Do you use a computer? ……………………………………………….. ☐ Yes ☐ No Hours/day ________
Do you have visual difficulty when driving? …………………………….. ☐ Yes ☐ No ☐ N/A
Do you have problems with night vision? ………………………………… ☐ Yes ☐ No
Do you have glare problems? …………………………………………….. ☐ Yes ☐ No

Spectacle Lens History

Do you currently wear glasses? .... ☐ Yes ☐ No Number of years________
What type? ………….. ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Safety Rx ☐ Sports Rx ☐ Progressive
Do you wear sunglasses? .... ☐ Yes ☐ No
Are your sunglasses in your prescription ………………………………. ☐ Yes ☐ No
Have you had trouble in the past with glasses? ………………………… ☐ Yes ☐ No
If yes explain ____

Contact Lens History

Have you ever tried to wear contact lenses? ……………………………… ☐ Yes ☐ No
Are you interested in trying contact lenses at this time? ………………… ☐ Yes ☐ No
Do you currently wear contact lenses…………………………………….. ☐ Yes ☐ No

How many hours/day? _________ How many days/week? _________
Type and Brand of Contact lenses ______________________
Current Wear schedule ………………………………… ☐ Daily disposal ☐ 2 Weeks ☐30days
☐other_____________
What solutions do you use? ___________________________

Please rate your current Contacts Lens on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

Lens Comfort:	(R)_____	Distance Vision:	(R)_____	Near Vision:	(R)_____
	(L)_____		(L)_____		(L)_____

Social History

Do you use nutritional supplements (vitamins, etc)? .... ☐ Yes ☐ No
Do you engage in regular exercise? ……………………………………… ☐ Yes ☐ No
Do you drink alcohol? If yes, how much/often: ……. ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3/day ☐ 4+/day
Do you smoke? If yes, how much/often: …………… ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+pack/day
Hobbies/Interests:

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (Gardening, welding, etc.)
☐ Sports/Hobbies (racquet sports, motorcycle)

Family Vision Center

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3002 Horizon Rd.
Rockwall, TX 75032

Medical History Questionnaire

Patient Name: __________________________male/female **Today's Date** / /

Name of Medical Doctor: ___________________________ Dr's. Phone _______________________________

Last Medical Exam _____/______/______

Medical History

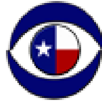
1. Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: ______________________________________
____
2. List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
____
____
____
3. List all major injuries, surgeries and /or hospitalizations you have had:
____
____
4. List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or injury: ____
5. Are you pregnant or nursing ☐ Yes ☐ No

Family History

Please note any family history (yourself, parents, grandparents, siblings, children; living or deceased) for the following:

	Yourself		**Family Member**			**Yourself**		**Family Member**	
	Yes	No	Yes	No		Yes	No	Yes	No
AIDS/HIV	☐	☐	☐	☐	Hepatitis (Type____)	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	☐	Lazy Eye	☐	☐	☐	☐
Artificial Joints	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Migraine Headaches	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	Pacemaker	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	Poor Color Vision	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Retinal Disease	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Rheumatic Fever	☐	☐	☐	☐
Chemical Dependency	☐	☐	☐	☐	Shingles	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Skin Conditions	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Drug Sensitivity	☐	☐	☐	☐	Thyroid Conditions	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	Turned Eye	☐	☐	☐	☐
Eye Surgery	☐	☐	☐	☐	Macular Degeneration	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐					
Hay Fever	☐	☐	☐	☐					
Heart Condition	☐	☐	☐	☐					

Dr.'s Signature ________________________________



FAMILY VISION CENTER

RETINAL PHOTOGRAPHS ARE STRONGLY RECOMMENDED BY ALL EYE SPECIALISTS

We have added a procedure to the routine eye exam recommended for patients over the age of 18. We will now be taking a photo image of your retina that will aid us in better diagnosing eye health. Retinal photography can assist us in the early detection of eye diseases, pre-cancerous and cancerous lesions, diabetic retinopathy, AIDS related retinopathy, optic nerve disease, macular degeneration, retinal detachments, toxic conditions, etc. The photographs are painless and done with a highly sophisticated computerized camera.

There is an additional charge $20.00 and **not** billed to insurance.
This test is highly recommended by the
American Optometric Association
and your doctor for everyone over 18.

Signature ________________________________ Date: ______________ Please check one ❑**Yes**❑**No**

____