Date: 5/4/20 **Family Eyecare (908) 259-5059** **15678**

Guardian:

Name:

Address:

City, St: **Zip:**

Phone(H): **(C):**

Date of Birth: **Sex:**

Social Security #:

Vision or Primary Insurance

Ins.: **#:**

Insured: **DOB:**

Relationship:

Medical or Secondary Insurance

Ins.: **#:**

Insured: **DOB:**

Relationship:

E-Mail:

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Referred by (name of friend we can thank)

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Medical Doctor(s)

Approx. Date of Last Eye Exam:

Glasses R-
L-

Contacts R-
L-

Allergies
☐ None
☐ Penicillin
☐ Sulfa
☐ Eye drops
☐ Other...

Current Medicines

Race **Ethnicity** **Language**

History or Problems

☐ Allergy ☐ Eye Infection ☐ Lazy Eye
☐ Amblyopia ☐ Eye Injury ☐ Macular Degen.
☐ Asthma ☐ Eye Surgery ☐ Migraine
☐ Cancer ☐ Gastrointestinal ☐ MS
☐ Cataract ☐ Glaucoma ☐ Psychological
☐ Crossed Eyes ☐ Heart ☐ Sinus
☐ Diabetes I ☐ High B.P. ☐ Thyroid
☐ Diabetes II ☐ Keratoconus ☐ Other...
☐ Droopy Lid ☐ Kidney
☐ Ear Problem ☐ Lasik

Eye wear History (have you ever worn...)

☐ Glasses ☐ No- line ☐ Gas Perm ☐ Disposable
☐ Bifocals ☐ Soft Contacts ☐ Hard ☐ Overnight wear
☐ Trifocals ☐ Toric Soft ☐ Monovision ☐ Other...

Family History (parents, grandparents, siblings)

☐ Blindness ☐ Kidney Disease ☐ High B.P. ☐ Other...
☐ Cataracts ☐ Macular Degen. ☐ Thyroid
☐ Crossed Eyes ☐ Retina Disease ☐ Glaucoma
☐ Color Blind ☐ Retina Detach ☐ Cancer
☐ Diabetes ☐ Heart Disease ☐ None

Pharmacy Name, Phone, Address

Occupation

Social History

☐ Computer ☐ Drug Use ☐ Current Light smoker
☐ Reading ☐ Alcohol Use ☐ Current every day smoker
☐ Student ☐ Never smoker ☐ Other...
☐ Swim ☐ Former smoker

Current eye problem(s) (please circle the "main" problem)

☐ Blur at Far ☐ Eye pain ☐ Spots or shadows
☐ Blur at Near ☐ Eye strain ☐ Diabetes eye check
☐ Blur at Far & Near ☐ Flashes/Floaters ☐ Medical eye check
☐ Itching ☐ Loss of vision ☐ Other...
☐ Burning ☐ Double vision
☐ Redness ☐ Sandy/Gritty

☐ Right eye ☐ Left ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

☐ Started today ☐ 3-7 days ☐ 2-4 weeks ☐ 3-6 months
☐ 1-2 days ☐ 1-2 weeks ☐ 1-3 months ☐ Over 6 months

☐ Getting better ☐ Getting worse ☐ About the same

Are you interested in contact lenses information?

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay. If your insurance policy has a deductable, you are responsible for the payment for the visit prior to being seen.** Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 50.0% of the amount owing which may be assessed by a collection agency. Please note when purchasing glasses or contact lenses there are no refunds and/or exchanges since the product is customized to each patient. Store credit only. **Contact lens fit and follow up care is billed separately from your eye exam and to be paid on the day of the fitting. Contact lens fit is $60 unless stated otherwise in your insurance policy. First time contact lens wearer will have $25 insert and removal fee.** Your information is protected by our privacy policy. **Your appointment time is reserved for you! If you are unable to keep your scheduled appointment time, PLEASE give us a 24 HOURS ADVANCE NOTICE to ensure that you will not be charged for the appointment.** I acknowledge **the charge for missed appointment is $50.**

Signature________________________ Date______________ Relationship to Patient ______________________

Printed: 5/4/20 DOB: 15678 Signed