# *FAMILY EYE CARE ASSOCIATES*

*Please complete all the information requested and print clearly so that your claim can processed quickly and efficiently.

**Patient Information**

Today's Date: _____ Patient Name: _____

Date of Birth:_____ Social Security # _____

Patient's preferred language: _____ Occupation(Indicate if Student):_____

Mailing Address: _____ Apt Number: _____

City:_____State:_____ Zip:_____

Home Phone: _____Cell: _____ Work:_____

Guarantor*(**only complete if the patient is not responsible**): _____DOB:_____

Relationship to patient: _____ Guarantor's SS#_____

Guarantor address (**if different from patient address**): _____Apt:_____

_____(city), _____ (state) Guarantor phone: _____

Primary Care Physican:_____ Referring Physician: _____

Marital Status: (please check) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Insurance Information: Please return this form with your Driver's License and Proof of Insurance(s). If your name is NOT ON THE CARD, please supply us with the following information**:

Subscriber's Name on Card (***if not yours***):_____

Relationship to Patient: (check) ☐ Self ☐ Spouse ☐ Dependent / Gender: (check) ☐ Male ☐ Female

Subscriber's SS#:_____ Subscriber Date of Birth: _____

## Financial Policy

All co-payments and deductibles are due at the time of service. Full payment is due at time of service for all noncovered services. Our contract with your insurance company requires us to collect these from you. **Payment in full is required without proof of insurance coverage.**

It is your responsibility to give us accurate and updated insurance information at each visit. Failure to do so may result in your being responsible for a balance that your insurance company may have otherwise paid. **If you receive a bill that you feel is not your responsibility, it is important for you to call the billing office. (478-453-9333)** Never ignore a bill simply because you feel it is not your obligation or you think your insurance company should pay it. We only transfer responsibility to you after we have had response from your insurance company.

**I have read the above statement and agree to its terms and conditions,**

_____ _____

(Signature of patient or legal representative) (Date)

# FAMILY EYE CARE ASSOCIATES

## Patient Name: _____

***Please describe the reason for your visit today*: _____**

**Will we be filing today's visit under your wellness plan? ☐ YES ☐ NO**

**Are you experiencing any of the following ocular symptoms: (circle and specify which eye)**

Pain Foreign Body Sensation Dryness Tearing Light Flashes

Double Vision Itching Light Sensitivity Floaters Blurred Vision

Glare at Night Burning Other: _____

---

**☐ Check here if you have had NO changes to the information requested below since your last visit:**

| List Allergies to Medications: | | List Current Medications: | | List Eye Medications: |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Who is your medical doctor? _____ Phone (if you know): _____

What pharmacy do you use? _____ Phone (if you know): _____

*Circle the appropriate answer:*

Do you smoke? NO/ YES (Pack Per Day-____) Do you use any other tobacco products? NO/YES-_____

Do you drink Alcohol? NO/YES- ☐ rarely ☐ socially ☐ occasional ☐ moderately ☐ heavy

Do you use any illegal drugs? YES/NO

*Please turn over!!*

HEALTH HISTORY:

| Condition | Self: Check if you have any of these conditions: | Family: Specify "mother, sibling, father" etc. if any of your family members have any of the following: |
|---|---|---|
| Heart Trouble | ☐ | |
| High Blood Pressure | ☐ | |
| Cholesterol | ☐ | |
| Asthma/Emphysema | ☐ | |
| Tuberculosis | ☐ | |
| Stroke/Palsy | ☐ | |
| Diabetes | ☐ | |
| Thyroid | ☐ | |
| Anemia/Blood disorder | ☐ | |
| Hepatitis | ☐ | |
| HIV/AIDS | ☐ | |
| Arthritis | ☐ | |
| Kidney/Bladder | ☐ | |
| Stomach/Intestinal | ☐ | |
| Mental Disorder | ☐ | |
| Cancer/ Tumor | ☐ | |
| Head Injury | ☐ | |
| Lupus | ☐ | |
| Seizures | ☐ | |

Other: _____

**PAST SURGICAL HISTORY**: _____

_____

_____

| Eye History | Self: Check if you have any of these conditions: | Family: Specify "mother, sibling, father" etc. if any of your family members have any of the following: |
|---|---|---|
| Lazy Eye | ☐ | |
| Cataract | ☐ | |
| Glaucoma | ☐ | |
| Blindness | ☐ | |
| Eye Injury | ☐ | |
| Eye Surgery | ☐ | |
| Crossed Eyes | ☐ | |
| Retinal Detachment | ☐ | |
| Macular Degeneration | ☐ | |

***To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.***

_____ _____ _____

*Signature of Patient, Parent, or Guardian* *Date*