F A M I L Y E Y E C A R E A S S O C I A T E S

*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 # _____

Guardian (if under 18): _____ Email:_____

Mailing Address: _____ Apt Number: _____

City:_____State:_____ Zip:_____

Home Phone: _____ Cell:_____

Occupation(Indicate if Student):_____ Work Phone Number: _____

Guarantor (responsible party if under 18): _____ Guarantor Phone: _____

Primary Care Physician:_____ 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)

FAMILY EYE CARE ASSOCIATES
Medical History

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: _____

_____

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? NO/YES

Please turn over!!

HEALTH HISTORY:

Condition	CHECK **IF** YOU HAVE ANY OF THESE CONDITIONS	**Write: "Mother," Sibling, etc. if any of your family members have these conditions (If not, leave blank)**
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	**Check if "yes" for self**	**Relative: Specify Mother, Sibling, etc.**
Lazy Eye	□	
Cataract	□	
Glaucoma	□	
Blindness	□	
Eye Injury	□	
Eye Surgery	□	
Crossed Eyes	□	
Retinal Detachment	□	
Macular Degeneration	□	
Glasses/Contact Lens Wearer	□	

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*

FAMILY EYE CARE ASSOCIATES

REFRACTION SERVICE FEE

A refraction is the process of determining your best corrected vision. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses as well as surgical evaluations. We are required to bill separately for this procedure.

Traditional Medicare (Red, White, and Blue card) never covers routine vision or dental services.

Our office fee for a refraction is $20.00. Should your plan pay us for the refraction, we will reimburse you accordingly.

□ ***I consent*** **to having a refraction done today for a prescription (for glasses or contact lenses) and understand that it is not a covered part of my exam.**

_____ _____

Patient Signature (or guardian) **Staff Witness**

-OR-

□ ***I decline*** **the refraction today and understand that without a current glasses prescription, I will not be able to get glasses or contacts lenses and/or reschedule relevant appointments for surgical evaluation.**

_____ _____

Patient Signature (or guardian) **Staff Witness**

AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

ACCT# _____

DATE: _____