F. Y. Eye Care Associates, O.D., PA

1. Patient Information

Check title below: Date _____

☐ Mr. ☐Mrs. ☐Ms. ☐Dr. ☐ Rev. ☐ Professor ☐Sister

Patient Name: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birth date: _____

Marital status: ☐ Single ☐Married ☐Widowed

Occupation: _____ Employer: _____

How did you hear about our practice? ☐ Yellow Pages

☐ Friend/Relative ☐Other _____

Who may we thank for referring you to our practice?

2. Insurance Information

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Company: _____

Insurance ID#: _____Group #: _____

Subscriber birth date: _____

Is this patient covered by an additional insurance? ☐ Yes ☐ No
If yes, please fill out secondary coverage information below.

Secondary Coverage Information

Subscriber Name _____

Relationship to patient: _____

Insurance Company: _____

Insurance ID#: _____Group #: _____

Subscriber birth date: _____

3. Phone Numbers / Email / Emergency Contact Information

Home phone _____ Work phone _____ Cell phone _____

Email address (optional): _____ May we contact you via e-mail ☐ Yes ☐ No

Preferred method of contact ☐ Cell phone ☐ Home phone ☐ Work Phone ☐ Email

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home phone _____ Work phone _____ Cell phone _____

4. Eye Health History

Date of Last eye exam: _____

Doctor's name: _____

Do you wear glasses? ☐Yes ☐ No
☐ Full-time ☐ Part-time
☐ Reading/Computer ☐ Driving ☐ Television

Do you wear contacts? ☐ Yes ☐ No

Type/ Brand _____

Contact lens cleaner_____

Place a checkmark on Yes or No to indicate if you are experiencing any of the following:

Blurred Vision – distance	☐Yes	☐No	Floaters or Spots	☐Yes	☐No
Blurred Vision – near	☐Yes	☐No	Glaucoma	☐Yes	☐No
Burning eyes	☐Yes	☐No	Headaches	☐Yes	☐No
Cataracts	☐Yes	☐No	Itchy eyes	☐Yes	☐No
Color Vision, poor	☐Yes	☐No	Lazy Eye (not correctable to 20/20)	☐Yes	☐ No
Crossed eyes	☐Yes	☐No	Light sensitive	☐Yes	☐No
Discharge from eyes	☐Yes	☐No	Loss of vision	☐Yes	☐No
Dizzy spells	☐Yes	☐No	Night vision, Poor	☐Yes	☐No
Double vision	☐Yes	☐No	Red Eyes	☐Yes	☐No
Dry Eyes	☐Yes	☐No	Seeing halos	☐Yes	☐No
Eye Infection	☐Yes	☐No	Seeing flashes	☐Yes	☐No
Eye Injury	☐Yes	☐No	Twitching eyelids	☐Yes	☐No
Eye Surgery	☐Yes	☐No	Watering eyes	☐Yes	☐No
Eye Turn	☐Yes	☐No			

How often do you replace your lenses? _____ Do you sleep in your lenses? ☐Yes ☐No How Often? _____

If you do not currently wear contacts, are you interested in being fit for contacts? ☐ Yes ☐ No

Please describe any eye injuries or surgeries_____

_____

5. Health History / Family Health History

Physician's name: _____ Date of last visit: _____

Place a checkmark on Yes or No to indicate if you have had any of the following. For the indicated items, place a checkmark to indicate if a blood relative has had any of the following:

Systemic Conditions:

	Yourself	Family Members		Yourself	Family Members
Arthritis	☐Yes ☐No		Kidney Disease	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No		Lupus	☐Yes ☐No	
Cancer	☐Yes ☐No	☐Yes ☐No	Migraine Headaches	☐Yes ☐No	
Diabetes	☐Yes ☐No	☐Yes ☐No	Shingles	☐Yes ☐No	
Heart Condition	☐Yes ☐No	☐Yes ☐No	Skin condition	☐Yes ☐No	
Hepatitis, Type ___	☐Yes ☐No		High Blood Pressure	☐Yes ☐No	☐Yes ☐No
Thyroid condition	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	
HIV+/ Aids	☐Yes ☐No				

Ocular Conditions:

Blindness	☐Yes ☐No	☐Yes ☐No	Describe: _____
Cataracts	☐Yes ☐No	☐Yes ☐No	
Glaucoma	☐Yes ☐No	☐Yes ☐No	
Macular Degeneration	☐Yes ☐No	☐Yes ☐No	
Retinal Disease	☐Yes ☐No	☐Yes ☐No	Describe: _____
Other: _____	☐Yes ☐No	☐Yes ☐No	Describe: _____

Other health conditions, please list: _____

Are you pregnant? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Tobacco? ☐ Yes ☐ No Recreational drugs? ☐ Yes ☐ No

List your current medications: _____

Please list your allergies to medications or other substances: _____

6. Signature on File

I the undersigned certify that I (or my dependent) have insurance coverage with the companies listed in section 2 of this form and assign directly to Dr. Karen Jones / F Y Eye Care Associates, OD, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/practice to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Patient or authorized person's signature _____ Date _____

7. HIPPA PRIVACY POLICY ACKNOWLEDGEMENT

I have been presented with the notice of Privacy Policy at this office and am aware that I may have a copy, if I desire, for my own records.

Please initial **ONE** of the items below.

_____ (initial here) I here by acknowledge that I have been presented a copy of the Privacy Policy

_____ (initial here) I hereby **refuse** to acknowledge receipt of the Privacy Policy. I understand that even though I refuse to sign this acknowledgement, I may still receive treatment from this office.

8. CHECK POLICY – We use Tele Check

When you provide a check as payment, you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) or a draft drawn from your account, or to process the payment as a check payment. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day you make your payment and you will **no**t receive your check back from your financial institution**. If your payment is returned unpaid, you authorize the collection of your payment and a return fee of $25 by EFT(s) or drafts(s) drawn from your account.**