Welcome to Fall Creek Vision Center!

PATIENT INFORMATION

Name: _____ Birth Date: _____ / _____ / _____

Nickname: _____ Title: _____ Suffix: _____ SSN: _____ - _____ - _____

Address: _____ Married Divorced Single Other: _____

City: _____ State: _____ Zip: _____ Please circle: Full-time Part-time Not employed Student

Home: (____)_____Day: (____)_____Cell: (____)_____ Retired Active duty Self-Employed

e-mail: _____ Employer: _____

(used for appt confirmation, glasses & contacts notifications, and recall purposes) Occupation: _____

Who referred you to us? _____

INSURANCE

☐ Same as above

Policyholder's Name: _____ Birth Date: _____ / _____ / _____ SSN: _____-_____-_____

SIGNATURES

Insurance Billing: **We do our best to work with your insurance company to maximize your benefits and save you money. However, the authorizations we receive are not guarantees of payment. By initialing below, you acknowledge that any unpaid balances left after insurance has been filed will become the responsibility of the patient or guarantor after 90 days.** **Initials:** _____

HIPAA : I acknowledge that I have received or been offered a copy of Fall Creek Vision Center's HIPAA privacy policies

Signature: _____ **Date:** _____

Records Release Authorization: I authorize Fall Creek Vision Center to release my exam records (if requested) to the following:

☐ Any and all providers ☐ Certain providers: _____

☐ Myself (email/mail) ☐ Parent/Guardian: _____ Other: _____

Signature: _____ **Date:** _____

MEDICAL HISTORY

Last eye exam: _____ Last medical exam: _____ Name of Medical Doctor: _____

Do you wear glasses? ☐ Yes ☐ No

How old is your current pair of glasses? _____

Do you wear contacts? ☐ Yes ☐ No

Do you sleep in your contacts? ☐ Yes ☐ No

What brand of CLs do you wear? _____

Do you have a recent onset of headaches? ☐ Yes ☐ No

Are you interested in Laser Eye Surgery? ☐ Yes ☐ No

Are you **allergic to any medications**? ☐ Yes ☐ No If yes, please list: _____

List **current** medications you take: _____

Women: Are you pregnant or nursing? ☐ Yes ☐ No

Have you ever, or are you currently experiencing the following? If yes, please check the box.

☐ blurred vision	☐ eye pain	☐ eye infection/pink eye	☐ double vision
☐ eye injury or surgery	☐ light sensitivity	☐ floaters	☐ light flashes
☐ watery eyes	☐ dry eyes	☐ eye redness	☐ vision loss

Please note any family history (parents, grandparents, siblings) for the following medical conditions. *Please list their relationship to you.*

	Self	Family		Self	Family		Self	Family
Allergies	☐	☐ _____	Heart disease	☐	☐ _____	Amblyopia/lazy eye	☐	☐ _____
Anemia	☐	☐ _____	High cholesterol	☐	☐ _____	Cataracts	☐	☐ _____
Arthritis	☐	☐ _____	Hypertension	☐	☐ _____	Glaucoma	☐	☐ _____
Asthma	☐	☐ _____	Migraines	☐	☐ _____	Macular degeneration	☐	☐ _____
Cancer	☐	☐ _____	Stroke	☐	☐ _____	Retinal disease	☐	☐ _____
Crohns	☐	☐ _____	Thyroid disease	☐	☐ _____	Strabismus/crossed eye	☐	☐ _____
Diabetes	☐	☐ _____	HIV	☐	☐ _____			