Family Eye Center

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Today's Date _____ **Email Address** _____

Last Name _____ **First Name** _____ MI _____
Address _____ **City** _____ **State** _____ **Zip** _____
Primary Phone # _____ **Secondary Phone #** _____
Date of Birth ___/__/_____ **Occupation** _____ **Employer** _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No **Referred by** _____ OR
How did you hear about us? _____
Who holds Insurance: _____ **Date of Birth:** _____
Primary Vision Coverage _____ ID Number _____
Medical Insurance Coverage _____ ID Number _____
Social Security Number: _____-_____-_____ Do you Smoke Yes/No If Yes how often? _____
Do you Drink Yes/No If yes how often per week? _____

Ethnicity: _____ **Decline to answer or specify:** _____
Hispanic or Latino: _____ Native Hawaiian/other Pacific Island: _____ Not Hispanic or Latino: _____

How is your general health _____ Do you take medications for any of the following:

(Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/no
Ears/Nose/Throat	Yes/No	Cholesterol Hi/Lo	Yes/No	Blood/Lymph	Yes/no
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/no
Respiratory	Yes/No	Integumentary(skin)	Yes/No	Headaches	Yes/no
High blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/no

Please explain _____
Diabetes Yes/No _____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No _____ Reactions? _____
Other health problems _____
Current medication(s) _____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History:

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal Detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No **EXPLAIN:** _____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Specify _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No		

HIPAA Acknowledgement & Confidential Communication Request

AUTHORIZATION

I, _____ , GIVE MY PERMISSION TO Family Eye Center and/or any staff member of Family Eye Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may included, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medications and/or RX, helping me understand my test results, helping me understand and make payments for my health care.

Name_____ Relationship_____ Phone# _____

Name_____ Relationship_____ Phone# _____

Please note: This form does not replace the release of Information form that must be completed to release PHI to another entity (person/business).

RESTRICTIONS

The following people shall not be allowed access to my Personal Health information:

Name_____ Relationship_____

Name_____ Relationship_____

Signature of Patient/Guardian: _____ Date: _____

Parent/Guardian Name (Please print): _____

If not signed by patient, please complete section below:

Name_____ Relationship_____