FIVE FORKS FAMILY EYECARE

General Information

First, Last, MI, Preferred Name: Male / Female

Date of Birth: Social Security Number:

Street Address: P.O. Box:

City, State, Zip:

Home Phone: Cell Phone:

Email:

Would you like to receive messages by: Email: Y N Text: Y N

Language: Race: Ethnicity:

Emergency Contact Name and Phone:

Insurance Information

Vision Insurance Plan (if any)? ☐ Eyemed ☐ First Choice ☐ Humana ☐ Healthy Connections

☐ Superior ☐ VSP ☐ Wellcare

Subscriber Name: DOB: SSN:

Primary Medical Insurance:

Subscriber Name: DOB: SSN:

Please note that most insurances do NOT cover the *Refraction* or the *Contact Lens Evaluation*.
You will be responsible for those fees at today's visit.

Patient Eye History

Date of Last Eye Exam:

Currently Wear Glasses? Y N

Currently Wear Contacts? Y N

If NO are you interested in Contact Lenses? Y N

Reason for Today's Visit?

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*Yes*	*No*	*Family*
Glaucoma	*Yes*	*No*	*Family*
Lazy Eye	*Yes*	*No*	*Family*
Macular Degeneration	*Yes*	*No*	*Family*
Retinal Problems	*Yes*	*No*	*Family*
Corneal Problems	*Yes*	*No*	*Family*
Diabetes	*Yes*	*No*	*Family*

Have you ever experienced, been diagnosed with, or treated for any of the following? Check all that apply.

☐ Headaches	☐ Dryness
☐ Blurry Vision	☐ Flashes/Floaters
☐ Double Vision	☐ Grittiness
☐ Crossed Eye/Eye Turn	☐ Iritis/Uveitis
☐ Corneal Abrasion	☐ Lazy Eye
☐ Tearing/Watering	☐ Corneal Erosion
☐ Glare Problems/Halos	☐ Light Sensitivity
☐ Itchiness	☐ Trouble seeing at night
☐ Burning	☐ Redness/Infections

Have you ever had any eye injuries or surgeries?

☐ **Yes** ☐ **No**

If YES, please list:

Patient Medical/Social History

Have you ever been diagnosed or treated for the following health problems? Check all that apply.

- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Weight Changes
- ☐ Head injury
- ☐ Decreased Hearing
- ☐ Tinnitus
- ☐ Hay Fever
- ☐ Sinus Pain
- ☐ Stuffiness
- ☐ Dry Mouth
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ COPD
- ☐ Cough
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Dryness of Skin
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Memory Loss
- ☐ Anxiety
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Alzheimer's
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizures
- ☐ Stroke
- ☐ TIA
- ☐ Cancer

Have you ever had any major surgeries?

☐ Yes ☐ No

If YES, Please list:

Tobacco Use:

- ☐ Never Smoked
- ☐ Current Smoker
  - # of Years
- ☐ Former Smoker
  - Discontinued:

Alcohol Use:

- ☐ Current Drinker
  - ☐ Everyday
  - ☐ Socially
- ☐ Former Drinker
  - Discontinued:
- ☐ Never

Are you Pregnant or Nursing?

☐ Yes ☐ No

Do you drive a vehicle?

☐ Yes ☐ No

Who is your Primary Care Physician?

Town:

Date of last Checkup:

Allergies to Medications:

☐ Yes ☐ No

If YES, what medications are you allergic to?

Current Medications: ☐ **Copy Provided**

Please include all Prescription and Over the Counter

Medication Name:	**Dosage:**

How did you hear about our office?

- ☐ Referral from:
- ☐ I am a previous patient of this office.
- ☐ This office takes my insurance
- ☐ Another Doctor
- ☐ Saw Sign/Building
- ☐ Facebook
- ☐ Newspaper
- ☐ Radio
- ☐ Yellow Pages
- ☐ Feidler Website
- ☐ Google

I authorize the release of any medical information necessary to process all insurance claims. I also authorize the release of payment for medical benefits directly to my physician. I am also aware that I am responsible for any charges that have not been paid, or been covered by my insurance.

Signature:

Date: