Welcome to our office!
Marysville Family Vision
Shimul Y. Shah, Optometrist

Today's date _____ Nickname: _____

Full Name: _____

Address: _____

DOB: _____ Gender: F M Spouse/Parent: _____

Cell # _____ Home # _____ Work # _____

Email _____

Preferred Contact Number: Home Cell Work Preferred Method: Call Text Email

Prev. Optometrist: _____ Last Eye Exam: _____

Name & Number of Emergency Contact: _____

Family Doctor and any specialist to receive correspondence: _____

*******INSURANCE INFORMATION FOR THE PERSON WHO CARRIES THE INSURANCE*******

If you have insurance we will gladly process your claim but we request that you pay your estimated portion, including copays, at the time of service. If, you realize more than 2 weeks after the date of your appointment that you have insurance then, we will be unalbe to back date the claim. We require a complete payment of any glasses or contacts at the time of ordering.

Subscriber's Name: _____

Subscriber's Social Security #: _____ Subscriber's DOB: _____

PLEASE PRESENT ANY VISION AND MEDICAL INSURANCE CARDS SO WE CAN MAKE COPIES. THANK YOU!

(CHECK ONE)

	Personal	Family	Relation
Allergies			
Arthristis			
Asthma			
Cancer			
Diabetes			
High B. Pressure			
Cholesterol			
Thyroid			
Glaucoma			
Cataracts			
Blindness			
Macular Degen.			
Eye Turn			

Please list all meds or give list:

_____

_____

_____

Please list all allergies or give list:

_____

Prev. Eye injury? Yes No

Details: _____

_____

Prev. Eye Surgery? Yes No

Details: _____

_____

How did you hear about our office?

_____

What is the major purpose of this visit? _____

_____

_____

Do you experience any of the following?

_____ Blur at distance	_____ Burning	_____ Flashes of Light
_____ Blur at computer	_____ Itching (Corners/Eyelids)	_____ Floating Spots
_____ Blur at near	_____ Tearing	_____ Nausea
_____ Double Vision	_____ Dryness	_____ Dizziness
_____ Glare on Computer	_____ Gritty Feeling	_____ Headaches
_____ Glare at night	_____ Redness	_____ Sensitivity to Light

Have you ever worn contact lenses? Yes No What kind? _____

Are you interested in trying or discussing contact lenses? Yes No

Do you use a handheld device or computer for extended hours? Yes No

Do you spend a lot of time outdoors? Yes No

Do you have 100% UV protecting glasses? Yes No

Are you interested in discussing surgical vision correction? _____

What do you like most about your current Glasses? _____

What do you like most about your current Contacts? _____

What is your biggest complaint about your current Glasses? _____

What is your biggest complaint about your current Contacts? _____

I have been presented with the Privacy Practices from Marysville Family Vision and I authorize the release of any medical information necessary for Marysville Family Vision to process all insurance claims, at any time, for medical services rendered. I request payment of all claims to be paid directly to MFV unless payment has already been rendered by me. I understand that I am responsible for any amount not covered by my insurance.

If I am ever to fill a prescription (contacts or glasses) obtained from another office, I understand that MFV is not responsible for any remakes if the prescription is incorrect. We will, however guaranty the lenses themselves and assume responsibility for the quality and accuracy of the lenses to the prescription that was presented. If I am ever to fill a prescription (contacts or glasses) at another office or online, MFV is not responsible for the quality of the product dispensed. We will, however, assume responsibility for the accuracy of the prescription.

Signature: _____ Date: _____