Name____ **Date of Birth**____________________ **Sex** (circle one) Male Female

Address____
(city) (state) (zip code)

Phone________________________________**Home** **Alternate Phone:**_______________________________**(cell /work)**

Social Security #____________________________ **Marital Status:** ______________ **Occupation**____________________

E-mail address:___________________________________ **How do you wish to be reminded of your future appointments :**
___ phone ____email ____ text (standard text rates apply)

Parent/Guardian Name (if minor):___________________________________ **Relationship to patient:**__________________

INSURANCE INFORMATION

Vision Insurance: (Vision insurance only covers for routine eye visits related to the updating of eyeglass or contact lens prescriptions.)

Insurance Name:____________________________ **Insurance ID #:**_______________________________

Policy Holder's Name: ____**Policy Holder's relationship to the patient:**___________

Group Name/Policy Holder's Employer:____ **Policy Holder's DOB:**__________________

Medical Insurance: (medical benefits cover any of today's services/testing that may be needed to address any medical eye complaints or conditions. We will also verify if you have any additional routine vision benefits through your medical insurance plan.)

Primary Insurance Company:__________________________________ **Insurance ID #:**_______________________________

Policy Holders Name: ____**Policy Holder's relationship to the patient:**________________

Group Name/Policy Holder's Employer:____ **Policy Holder's DOB:**________________

Is there any other secondary Medical Policy? Y or N What is the name of the Secondary plan ____________________________________

If you have Medicare as an additional insurance, is Medicare your _____Primary or ______ Secondary insurance?

FINANCIAL RESPONSIBILITY (all patients must read and sign)

I certify that the above information given by me is correct. I understand payment is due at the time services are rendered including at follow up office visits related to my eye conditions. If insurance benefits are being utilized for today's services, I hereby authorize and direct payment of my vision and/or medical benefits to Focusing on Eye Care, Inc. Every effort is made to obtain a quote of my insurance benefits at the time of service. I understand this quote of benefits is not a guarantee of payment. Final determination of payment is made when my insurance claim is submitted, and I understand that I am financially responsible for any non-covered services, co-payments, and deductibles. In the event that my vision/health plan determines a service to be "not covered" and denies payment for any reason, I understand that I am financially responsible for the complete charge. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that my signature on this form will serve as a permanent signature on file recognizing my financial responsibilities and will be used for accept assignment purposes only for those plans the doctors at Focusing on Eye Care, Inc. are participating providers for.

___________________________________ _________________________________
Signature of patient (or responsible party) Date

HIPAA ACKNOWLEDGEMENT

My signature confirms that I understand my contact information is used by our office to send appointment reminders , inform me of changes/ new technology implemented in this office or with the optical via phone, text, paper mail, or email, . My medical information is privileged information and is only released when I am referred to another provider for further eye care, to process insurance claims for payment of services rendered, or when I specifically release such information. I have been provided a copy of the Notice of Privacy Practices of Focusing on Eye Care, Inc. to review and have been offered a copy of such policy to keep for my records.

______________________________________ __________________________________
HIPAA Signature Date

Date:_______________

Visual History

Date of last eye exam________________ Age of current glasses___________________

Have you had an eye injury? ___no ____ yes If yes, explain____

Have you had eye surgery? ___no ____yes If yes, explain____

Do you wear Contacts? ___no ____yes If yes, what type? _______________________________________

Patient/Family Ocular & Medical History

Do you or anyone in your family have or have ever been treated for any of the following conditions?

	Self	Family	None
Glaucoma	□	□	□
Cataracts	□	□	□
Retinal Detachment	□	□	□
Macular Degeneration	□	□	□
Crossed Eyes/ Lazy Eye	□	□	□
Blindness	□	□	□
Head Injury	□	□	□
Diabetes	□	□	□
High Blood Pressure	□	□	□
Heart Disease	□	□	□
Stroke	□	□	□
Breathing Problems	□	□	□
Thyroid Disease	□	□	□
Cancer	□	□	□
Headache	□	□	□
Arthritis	□	□	□
Other_____________			

Patient's Review of Systems

Date of Last Medical Exam/Physical:_________________ Primary Care Doctor:____

Please Circle Yes if you currently have or have had past problems with any of the following areas:

Constitutional (Fever,Weight gain/loss) Yes
Integument (skin rash, pain) Yes
Neurological
- Headaches Yes
- Migraines Yes
- Seizures Yes
- Numbness Yes

Eyes
- Loss of Vision Yes
- Blurred Vision Yes
- Loss of Side Vision Yes
- Double Vision Yes
- Dryness or Sandy/Gritty Feeling Yes
- Redness Yes
- Itching Yes
- Foreign Body Sensation Yes
- Excess Tearing/Watering Yes
- Glare/Light Sensitivity Yes
- Chronic Eye Infections or styes Yes
- Flashes/Floaters in Vision Yes
- Eye Fatigue Yes

Endocrine
- Thyroid /Other Gland Disorders Yes
- Diabetes Yes

Allergic/Immunologic Yes

Ear, Nose, Mouth, Throat
- Allergies/Hay Fever Yes
- Sinus congestion Yes
- Chronic Cough Yes
- Vertigo Yes
- Dry Mouth/Throat Yes

Respiratory
- Asthma Yes
- Shortness of Breath Yes
- Emphysema Yes

Vascular/Cardiovascular
- Congestive Heart Failure Yes
- Chest Pain Yes
- Increased or Decreased Heart Rate Yes

Gastrointestinal
- Diarrhea or changes in bowel movements Yes
- Nausea or Vomiting Yes

Genitourinary
- Frequent or painful Urination Yes
- Sexually Transmitted infections Yes
  (Chlamydia, Gonorrhea, Syphilis, HIV, etc.)

Bones/Joints/Muscles
- Muscle or Joint Pain Yes

Lymphatic/Hematologic
- Recurrent Infections Yes
- Bruising or bleeding problems Yes

Psychiatric or mood changes Yes

Please Explain any conditions you answered Yes to or if you or if you any conditions not listed above:

Are you taking any medications ? (Include over the counter products, eye drops, and oral medications)

____

____

Do you have any allergies to foods, medications, environmental? ____no ____yes If yes explain_________________________

Are you currently pregnant or nursing? ____no _____yes

Do you have a history of recreational drug use? ___no ____yes If yes, type/amount/how long:_______________________

Do you drink alcohol or use tobacco products? ____no ____yes If yes, type/amount/how long:_______________________