Welcome to our office!

VISION SOURCE™ PONTIAC • FAIRBURY FAMILY EYE CARE • VISION CENTER

The People You Need to See!

Date _____ /_____ /_____

Last Name _____ First Name _____ Middle Initial _____

Title: Mr. Mrs. Ms. Dr. Other _____ Gender: M F Marital Status: Single Married Other

Birthdate _____ /_____ /_____ Social Security # _____ Driver Lic. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Race: *American Indian* *Asian* *Black/African American* *Hispanic* *Native Hawaiian/Pacific Islander* *White*

Ethnicity: *Hispanic* *Native Hawaiian/Pacific Islander* *Non-Hispanic*

Preferred Language: *English* *Spanish*

Occupation _____

Employer _____

Work Phone _____

First and Last names of immediate family who are patients in our office:

_____

_____

With whom besides yourself may we discuss your personal health related information (include name, relationship and contact phone):

_____

When we need to contact you to share personal health information we will generally use your home phone, cell phone, or your patient portal unless you specify another form of contact.

Notice of Privacy Practices — Acknowledgment of Receipt

I acknowledge that a Notice of Privacy Practices has been presented to me. I understand that "take home" copies are available at my request.

Signed: _____ Date _____ /_____ /_____

Medical Insurance — Primary: _____

Medical Insurance — Secondary: _____

Vision Plan: _____

We can bill some carriers for you. A list is available. All others must pay at time of service. Payment is expected for all non-covered services you receive. Any balance remaining 90 days after submission to your insurance company becomes your responsibility.

Parent, Guardian, Guarantor or Insured Individual Information

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ /_____ /_____ Soc. Sec. # (Last 4 digits) _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Patient or Patient Representative: I authorize the release of information to my insurance company as necessary to process my claim. I authorize payment of benefits to Family Eye Care of Pontiac, LLC for services I have received. I agree to pay all collection fees, court costs and reasonable attorney fees if I default on my account. I agree to pay a charge of $35.00 for any check that is returned by my bank. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date _____ /_____ /_____

The **iWellness Screening** is able to detect eye disease that could lead to severe vision loss. *Your doctor recommends that all adults receive an iWellness Screening at every annual examination - even if you think you are seeing clearly.* The $47 screening fee is not typically covered by health insurance or vision plans; however, our experience has proven that this imaging is very important. For children, we recommend just the Optomap Retinal Exam ($34). A technician will answer any questions you have in the pretest room.

_____ I have read this statement. (initial)

Who can we thank for referring you to our office? _____

Please complete Page 2

Personal Medical and Ocular History

Family Physician _____ Last Medical Exam _____ (yea) Last Eye Exam _____ (yea) (location)

Please mark all conditions you have been treated for or experienced:

Allergy
- ☐ Environmental

Cardiovascular
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ High Cholesterol
- ☐ Stroke

Constitutional
- ☐ Greater than usual thirst
- ☐ Greater than usual urination

Endocrine
- ☐ Diabetes
- ☐ Thyroid

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Colon Polyps

Genitourinary
- ☐ Kidney / Bladder

Ears, Nose, Throat
- ☐ Sinus Congestion
- ☐ Cold Sores
- ☐ Hearing Loss

Hematologic/Lymphatic
- ☐ Leukemia
- ☐ Anemia
- ☐ Breast Cancer
- ☐ Sickle Cell Disease

Immunologic
- ☐ Shingles
- ☐ Lyme Disease
- ☐ Sjogrens Syndrome
- ☐ Sarcoidosis

Integumentary
- ☐ Skin cancer
- ☐ Rosacea

Musculoskeletal
- ☐ Osteo-Arthritis
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Migraines
- ☐ Bell's Palsy
- ☐ Brain Tumor

Mental Health
- ☐ Anxiety
- ☐ Depression

Respiratory
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Histoplasmosis

If you have a condition not listed above, please name or describe below:

_____

_____

List any eye related surgeries you have had:

_____

_____

_____

List all other **major** surgeries you have had:

_____

_____

_____

Provide us a prepared list of any Rx and "over the counter" medications you take, including dosages, or write them below.

_____

_____

_____

_____

_____

Have you used medicines that have caused reactions or sensitivities? ☐ NO ☐ YES If yes, list medications:

_____

_____

Are you pregnant or nursing? ☐ NO ☐ YES Have you been infected with HIV or other STD? ☐ NO ☐ YES

Tobacco use: ☐ never ☐ Former smoker, stopped _____ years ago ☐ Current smoker, _____ packs/day ☐ Smokeless tobacco user

Alcohol use: ☐ none ☐ social use only ☐ 1-2 drinks/day ☐ 3-4 drinks/day ☐ More than 4 drinks/day

Family History

Please mark any family history of the following conditions (parents, grandparents, siblings, or children; living or deceased) :

- ☐ Blindness
- ☐ Cataract
- ☐ Turned Eye (strabismus)
- ☐ Lazy Eye (amblyopia)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Color "Blindness"
- ☐ Retinal tear or detachment
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Other _____