FAMILY VISION ASSOCIATES
YOUR VISION IS OUR FOCUS™

Last Name: _____ First Name: _____ Middle Initial: _____ Title: Mr. / Mrs. / Ms. / Dr.

Date of Birth: _____ Age: _____ Sex: F / M SSN: _____

Address:
_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Day Phone: _____

Language: _____ Race: _____ Ethnicity: _____

Email: _____ Date of Last Eye Exam: _____

Marital Status: Single / Married / Divorced / Widowed / Separated Student Status: Part Time / Full Time

Referred By: _____ Occupation: _____ Retired: ☐

Name of Spouse / Parent / Legal Guardian: _____ Date of Birth: _____

Vision Insurance:

Policy Holder Name: _____ Policy Holder SSN: _____ Policy Holder DOB: _____

Plan Name: _____ Policy Number: _____ Copay Amount: _____

Primary Medical Insurance:

Policy Holder Name: _____ Policy Holder SSN: _____ Policy Holder DOB: _____

Plan Name: _____ Policy Number: _____ Copay Amount: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Secondary Medical Insurance:

Policy Holder Name: _____ Policy Holder SSN: _____ Policy Holder DOB: _____

Plan Name: _____ Policy Number: _____ Copay Amount: _____

Group Name (if applicable): _____ Group Number (if applicable): _____

Emergency Contact: _____ Phone: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I understand that payment is expected at time of service. If my insurance is declined at any time, I am responsible for payment.

Responsible Party Signature: _____ Date: _____

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Reason for today's visit: ☐ Routine Eye Exam ☐
Other: _____

Do you wear: ☐ Glasses Constant Wear / Distance Only / Near Only / Bifocal or Progressive

☐ Contacts How often do you change them? _____ Do you sleep in them? Y / N Brand: _____

List all medications

Medication	Dosage	How often		Medication	Dosage	How often

Do you have any allergies to medications?
_____

Pharmacy Name: _____ Town: _____ Phone #: _____

Do you smoke? N / Y how much? _____ Do you drink alcohol? N / Y how much? _____

Personal Medical Information: Do you have problems with any of these systems? (Please Circle)

Gastrointestinal	Neurologic (migraines)	Psychiatric
Ear / Nose / Throat	Genitourinary	Endocrine (diabetes, thyroid)
Cardiovascular (high blood pressure)	Blood / Lymph	Respiratory (asthma)
Skin	Immunologic	Cancer (neoplastic)

Family history of any of the above: _____

Surgeries: _____

Personal Ocular History: Have you ever been diagnosed with any of the following? (Please Circle)

Glaucoma	Retinal Detachment	Cataracts
Macular Degeneration	Lazy Eye	Dry Eyes

Other: _____

Family history of any of the above: _____

Have you ever had any eye surgeries or injuries? : _____