WELCOME TO OUR OFFICE

Fayette EyeCare is committed to your eye and vision health. We hold firmly to the Values that we will provide QUALITY service, care and products to our patients; we will work as a Team; we will be Friendly, Positive and Professional; and You, the patient, always come FIRST. Please let us know how we are doing.

Please be certain to answer the following questions completely so that we are able to expedite your exam.

PERSONAL INFORMATION

Date ____________________

Patient Name ____
(Last) (First) (Middle)

Address ______________________________ City ______________________ Zip Code ________

Birth Date ______ /______ /______ SS# ______ / ______ / ______ Gender ❒ Male ❒ Female

Home Phone ______________________________ Cell Phone ______________________________

Email Address ______________________________ Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widow

Occupation ______________________________ Employer ______________________________

Emergency Contact ______________________________ Relationship: ____________ Phone: ____________

New Patients only: Who sent you to us or from what source did you get our name? (Please check one)

❒ Yellow Pages ❒ Internet ❒ Primary Care Physician ❒ Family/Friend (please list the name) ____________________

INSURANCE INFORMATION

Medical Insurance ____

Medical Insured's Name ______________________________ Insured's Birth date _____ / _____ / _____

Insured's SS# _____ / ____ / _____ Patient's relationship to the insured: ❒ Self ❒ Spouse ❒ Child ❒ Other ____________

Vision Insurance: ❒ VSP ❒ Vision Plus ❒ Vision Care Plan ❒ EyeMed ❒ Other ____________________

Visions Insured's Name ______________________________ Insured's Birth date _____ / _____ / _____

Insured's SS# _____ / ____ / _____ Patient's relationship to the insured: ❒ Self ❒ Spouse ❒ Child ❒ Other ____________

How is your general health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent

Who is your family physician? ______________________________ Date of last visit ____________________

YOUR FAMILY VISION HISTORY

Do you or any family members have a history of the following? **Please mark yes or no for all items**:

	Yes	No	Relationship		Yes	No	Relationship
High Blood Pressure	❒	❒	__________	Macular Degeneration	❒	❒	__________
Diabetes	❒	❒	__________	Retinal Detachment	❒	❒	__________
Glaucoma	❒	❒	__________	Cataracts	❒	❒	__________
Other Eye Conditions	❒	❒	Please list ______________________________				

My signature below authorizes Fayette EyeCare to release all information necessary to secure payment of benefits from my insurance company and for benefits to be paid directly to Fayette EyeCare.

I acknowledge that I have been provided with and read a copy of Fayette EyeCare's Notice of Privacy Practices that details how my health information can be used and shared.

I understand that I am financially responsible for all charges whether or not paid by insurance and that all professional fees are non-refundable and payable at the time of service.

Signature ______________________________ **Date** ____________________