

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 _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Eye Conditions	<input type="checkbox"/>	<input type="checkbox"/>	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 _____