WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Date of Birth _____Age _____
Sex M F
Email Address _____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Web Page: Which Web Site? _____
❑ Other _____

Communication

We currently send appointment reminders and appointment requests using e-mails and/or text messages. We do not release this information to any third parties.

Notices

I understand the Contact Lens Exam/ Fitting Policy
Initial _____

I understand the HIPPA Notice of Privacy Practices
Initial _____

I understand the Missed Appointment and Cancellation Policy
Initial

Waxhaw Family Vision Care
OD, PLLC
"our focus is your vision"

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment and understand I am responsible for any fee not paid by my insurance.

X_____

Insurance Information

Routine Vision Insurance_____
Subscriber Name_____
Subscriber id # _____
SS#_____
Subscriber Birth Date_____

Medical Insurance_____
Subscriber Name_____
Subscriber id # _____
SS#_____
Subscriber Birth Date_____

Do you participate in a Flex Spending Account or Health Savings Account?

❑ Yes ❑ No

Contact Lens Exam/ Fitting Policy

If you are a contact lens wearer or would like to be fit with contact lenses, there is a contact lens exam/ fitting fee in addition to your regular exam fees. This runs $39.00 to $149.00 depending on the level of care and time involved (typically $39.00 if there are no changes). This fee will automatically be charged to your annual exam to update your contact lenses prescription. Your routine vision insurance may or may not pay toward this; however, you are responsible for this fee at the time of service. If you do not wish to update your contact lens Rx, it is your responsibility to let us know before your examination.

The information in this confidential case history form is critical to the evaluation of your vision and health.

Family Medical History (check all that apply)

Is there a family medical history of any of the following:

Blindness	❑
Cataracts	❑
Corneal Problems	❑
Diabetic Eye Disease	❑
Glaucoma	❑
Lazy Eye	❑
Macular Degeneration	❑
Retinal Problems	❑

Patient Medical History

Name of Family Physician_____

Town_____

How long has it been since your last physical?

_____

Please list all medications you are currently taking including eye drops, vitamins, birth control, and over the counter. _____

_____

_____

_____

Please list any allergies to medications. ❑None known

_____

How long has it been since your last eye exam?

_____

Please list any previous eye injuries or surgeries.

_____

_____

_____

_____

_____

_____

_____

Patient Medical History

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Cataracts
❑ Double Vision	❑ Glaucoma
❑ Crossed /Lazy Eye	❑ Macular Degeneration
❑ Floaters	❑ Retinal Detachment
❑ Flashes of light	❑ Corneal Abrasion
❑ Dry Eyes	❑ Sunlight Sensitivity
❑ Burning Eyes	❑ Trouble seeing at night
❑ Itchy Eyes	❑ Eye Surgery
❑ Tearing	❑ Eye Injury

❑ Other eye disorders_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑