Susan E. Halstead, ABOC, FNAO

205 Lake Avenue, Saratoga Springs, NY 12866
518.584.6111 / Fax 581.580.8589
www.familyvisioncarecenter.com

Patient Personal Information

First Name_____ MI____

Last Name_____

Address_____

City_____

State_____ Zip_____

Date of Birth_____ /_____ /_____

Sex: M / F Marital Status: S / M / D / W

Employer_____

Occupation_____

Home Phone_____

Cell Phone_____

Work Phone_____

Parent/Guardian_____

Emergency Contact_____

Emergency Phone_____

Primary Care Doctor: _____

Pharmacy/Location: _____

E-MAIL & TEXT NOTIFICATIONS!!

On-line Appointment Requests • Text Notifications of Completed Orders • Appointment Confirmations
• Text Message Appointment Reminders • Satisfaction Surveys

Please provide information below so that we are better able to service you and your eye care needs!

Email: _____Cell: _____

Patient Insurance Information: Relationship to Insured: □ **Self** □ **Spouse** □ **Child**

Medical Ins. Carrier_____

ID#_____

Group #_____

Policy Holder's Name_____

Policy Holder's DOB _____ / _____ / _____

Policy Holder's SSN _____ - _____ - _____
(Required for Tricare/Humana Ins Billing)

Vision Ins. _____

ID#_____

Group # _____

Policy Holder's Name_____

Policy Holder's DOB _____ / _____ / _____

Policy Holder's SSN _____ - _____ - _____

Patient Medical History Name: _____ DOB: _____

What is the main purpose of this visit?_____ Year of last eye examination:_____

Were your eyes dilated at your last exam? □ yes □ no

Have you ever had a dilated exam? □ yes □ no

Are you Pregnant? □ yes □ no

Are you Nursing? □ yes □ no

Are you a Contact Lens Wearer? □ yes □ no

Brand_____

Right Eye Rx_____ Left Eye Rx_____
(include BC & DIA parameters) (include BC & DIA parameters)

Have you had LASIK/PRK surgery? □ yes □ no

Dr's Name:_____

Date of Surgery:_____

Are you interested in LASIK? □ yes □ no

List all allergies (environmental or drug): _____

Current medications or supplements: _____

_____

Do you have Diabetes? □ yes □ no
□ Type I □ Type II

Year diagnosed: _____
Last HbA1C: _____

Do you/have you ever used tobacco products? □ yes □ no
Type:_____ Amount:_____ How long?_____

Do you drink alcohol? □ yes □ no
Type:_____ Amount: _____ How long? _____

Have you ever been diagnosed/treated for the following?

Cataracts □ yes □ no
Glaucoma □ yes □ no
Macular Degeneration □ yes □ no
Retinal Detachment □ yes □ no
Lazy Eye or Eye Turn □ yes □ no
Eye Injury □ yes □ no
Eye Surgery □ yes □ no

If yes, provide details: _____
_____

Do you experience any of the following?

Blurry Vision □ yes □ no
If so: □ distance □ near □ both
Difficulty at computer □ yes □ no
Difficulty driving at night □ yes □ no
Dry Eye □ yes □ no
Headaches □ yes □ no
Double Vision □ yes □ no
Flashes of Light □ yes □ no
Persistent Floaters □ yes □ no
Eye Itching □ yes □ no
Eye Tearing □ yes □ no

Have you ever been diagnosed or treated for any of the following problems? *Explanation of Problem*

Endocrine (thyroid, hormones, glands) □ yes □ no _____
Cardiovascular (heart, blood vessels) □ yes □ no _____
High Blood Pressure □ yes □ no _____
Respiratory (lungs, breathing) □ yes □ no _____
Gastrointestinal (stomach, intestines) □ yes □ no _____
Musculoskeletal (muscles, joints, arthritis) □ yes □ no _____
Integument (skin) □ yes □ no _____
Neurological (migraines, seizures) □ yes □ no _____
Psychiatric (anxiety, depression, etc) □ yes □ no _____
Ears, Nose, Mouth, Throat □ yes □ no _____
Hematologic/Lymphatic (anemia, etc) □ yes □ no _____
Allergic/Immunologic □ yes □ no _____
HIV/AIDS □ yes □ no _____

Do you have a family medical history of any of the following:

Glaucoma □ yes □ no Relationship: _____ (Maternal / Paternal)

Lazy Eye □ yes □ no Relationship: _____ (Maternal / Paternal)

Macular Degeneration □ yes □ no Relationship: _____ (Maternal / Paternal)

Color Blindness □ yes □ no Relationship: _____ (Maternal / Paternal)

Other Vision History _____

Preferred Language:

□ English
□ Spanish

Race*: (Please indicate all that apply below)*

□ White
□ American Indian or Alaskan Native
□ Asian
□ African American
□ Hispanic
□ Native Hawaiian or Pacific Islander

Ethnicity:

□ Not Hispanic or Latino
□ Native Hawaiian/ Other Pacific Islander

Communication Preference:

□ Email
□ Text
□ Mail
□ Telephone

Referred by: □ Patient:_____ □ Professional:_____ □ Other:_____

Contact Lens Management (for current wearers only): For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and the condition of the eyes while wearing contact lenses. We also evaluate changes in prescription and lens design during this process. **Soft contact lens evaluation and new prescription is $35; refitting to a new brand of contact lens will cost between $50 and $199, depending on the type of lens being fit. The fees for Custom or RGP contact lens evaluations and refits vary. Please ask the Staff or your Optometrist for details.**

Financial Responsibility & Benefits Coverage

I understand that the doctor(s) may or may not be participating with my insurance carrier and I am fiscally responsible for all charges whether or not paid by my insurance company. I give my permission to bill my insurance company with the understanding that I am responsible for all charges whether or not paid by my insurance carrier. I understand that I am responsible for and aware of my eyewear benefits coverage and it is my responsibility to make that information known at time of purchase. I understand that I will forfeit such benefits if they are provided after merchandise has been completed and/or provided. I understand that **the fee for returned checks is $50.00, and the fee for a missed appointment without 24-hour notice is $50.00.**

Please sign below that you have reviewed all of the information above and it is correct to the best of your knowledge.

Signature_____ Printed Name_____ Date_____
(Required)