Welcome to Advanced Family Eye Care

Name: ____ Sex: (Circle one) Male Female

Address: ____ Today's Date: ____/______/______

City:_______________________State___________________Zip________________ Ok to text msg: _____

Phone: ___________________ Work Phone: _____________________ Cell Phone: ___________________

Email: ________________________________ Preferred Communication: (Circle one) Phone Email Text

Race: _____________________ Ethnicity: __________________ Preferred Language: _________________

Birth Date: ______/_____/_____Social Security #: _____-____-_______Employer:___________________

Parent or Guardian (please print name)_______________________________ Relationship_________________

Parent or Guardian (please print name)_______________________________ Relationship_________________

Employment Status: (Circle one) Full-time Part-time Temporary

How did you hear about our practice? _________________________Marital Status: (circle one) **S or M**

Name of Medical Doctor: _________________________________Last Eye Exam:______/_____/_______

List any medications you currently take (Rx and over-the-counter):_______________________________
____

Do you have allergies to any medications? YES NO If YES, list the medications:____________________

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):____

List any surgeries you have had (cataract, appendectomy):_______________________________________

Insurance Information

Vision Insurance Company: _________________________________ID Number: _____________________

Subscriber Name: ____Group Number: _________________

Subscriber Date of Birth: _____ /_____ /_______Subscriber Social Security Number: _____-____-_____

Relationship to Patient:_______________________________________

Medical Insurance Company: __________________________________ID Number: ____________________

Subscriber Name: ____Group Number: _________________

Subscriber Date of Birth: _____ /_____ /_______Subscriber Social Security Number: _____-____-_____

Relationship to Patient:_____________________________________

Financially Responsible Party for Patient (if different from Patient or Patient is a minor)

Name: ____ Date of Birth: _____ /_____ /_______

Address (if Different from Patient) ___________________Social Security Number: ______-____-_____ Phone Number: ______