FAMILY OPTOMETRIC CARE

J. Brent Meek, O.D. ▪ Lisa A. Kopper, O.D.

How were you made aware of our office? _____ Today's Date_____

Patient's Full Name _____Nickname_____

Gender: Male / Female Marital Status: Single____ Married____ Divorced____ Other____

Mailing Address _____City _____

State _____ Zip _____ Home Phone _____ Alt Phone _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ SSN _____

E-Mail Address_____

I would like my yearly appointment recall reminders by: _____Mail _____Email

I would like my courtesy appointment reminders by: _____Phone _____Email

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Insurance for Eye Care _____ Insured Party's Name _____

Date of Birth _____ SSN or PIN _____ Employer_____

Relationship to Patient _____ Phone _____

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FEE POLICIES

The patient, not the insurance company, is responsible for his/her bill.

If current insurance information is provided, we will bill insurance for any covered services and materials. Copays, deductibles or charges not covered by your insurance are to be paid in full at the time of service. If you have any questions regarding fees or any of the information explained above, please discuss it with the receptionist **before** you see the doctor.

I have read and understand the fee policies and agree to pay for services rendered.

_____

Signature (Patient, Parent or Guardian)

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign this Acknowledgement****

The undersigned Patient or legally authorized representative of the Patient acknowledges that he or she personally received a copy of Family Optometric Care's Notice of Privacy Policies.

Signature:_____ Date:_____

Patient:_____

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies. Acknowledgement could not be obtained because:

_____Individual refused to sign _____Communication barriers _____ Other (Specify:)_____

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Patient Information

Patient Name_____ Date of Birth_____

General Medical Doctor _____ Address_____

Last Eye Exam _____ Do you now or have you ever worn glasses? Y/N

Do you now or have you ever worn contacts? Y/N Are you interested in contacts? Y/N

What brand of contact lenses have you previously worn?_____

Are you Pregnant: Yes / No Alcohol Use: Y/N Amount:_____

Past Tobacco Use: Y/N Amount:_____ Current Tobacco Use: Y/N Amount:_____

List **Medications** you are currently taking and dosages if known:

Allergies to Medication:

Have you been diagnosed as having any of the following conditions?

_____Diabetes (Type I/Type II)	_____Kidney Disease	_____Stroke
_____High Blood Pressure	_____Thyroid Disease	_____Cancer_____
_____Heart Disease	_____Serious Head Injury	_____TB
_____High Cholesterol	_____Allergies	_____STD
_____Asthma	_____Migraines	_____Arthritis
_____Macular Degeneration	_____Glaucoma	_____Cataracts

_____Other:_____

List those in your immediate family (Father, Mother, Brother, Sister, Son, or Daughter) who have been diagnosed with any of the following conditions:

_____Macular Degeneration	_____Glaucoma	_____Cataracts
_____High Blood Pressure	_____Thyroid Disease	_____Cancer_____
_____Diabetes (Type I/Type II)		

Please check the following eye symptoms that presently apply:

_____Light Flashes	_____Dryness	_____Double Vision
_____Floaters	_____Burning	_____Color Blindness
_____Discharge from Eyes	_____Light Sensitivity	_____Trouble Reading
_____Difficulty Seeing at Night	_____Excessive Watering	Other:_____
_____Episodes of Temporary Loss of Vision		

Have you previously had any eye diseases, injury, or surgery? Y/N Please List:_____

_____