Welcome to Our Office!

We appreciate your taking the time to complete this form. This information will help us understand your vision history and any future needs you may have.

Quality Family Eyecare

647 Lime City Road
Rossford, Ohio 43460
PH: 419.666.0700
FAX: 419.666.9605

Patient Name_____ Nickname_____ Date _____

Address _____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth _____ Age _____ SS#_____ Sex: M F Marital Status: S M D W

Occupation/Student_____ Employer/School _____

Employer's Address _____ Email _____

Spouse (or Parent's) Name_____ Spouse (or Parent's) Work _____

Family Doctor _____ Referred By _____

Emergency Contact Person_____

Vision History

Date of Last Eye Exam _____ By Whom_____

History of treatment or diagnosis of: (*Please circle any that apply.*) Cataracts • Crossed Eye • Glaucoma • Retinal Detachment Macular Degeneration • Eye Injury • Floaters/Spots • Irits/Uveitis • Dry Eye • Corneal Abrasions

Medical History

PATIENT HISTORY

Date of Last Physical Exam _____

Do you currently have any problem in the following areas?
(*Please check Yes or NO and explain "YES" answers.*)

Ears, Nose, Throat	☐YES ☐NO	_____
Heart (*past or current*)	☐YES ☐NO	_____
Lungs/Breathing	☐YES ☐NO	_____
High Blood Pressure	☐YES ☐NO	_____
Genital/Urinary, Intestinal	☐YES ☐NO	_____
Muscle/Bone/Joints	☐YES ☐NO	_____
Skin and/or Breast	☐YES ☐NO	_____
Psychiatric	☐YES ☐NO	_____
Diabetes, Thyroid, Glands	☐YES ☐NO	_____
Blood, Lymph Nodes	☐YES ☐NO	_____
Allergies, Immunologic	☐YES ☐NO	_____
Cancer	☐YES ☐NO	_____
Neurological	☐YES ☐NO	_____

FAMILY HISTORY

Are there any blood relatives with the following conditions?

Blindness	☐YES	☐NO
Cataract	☐YES	☐NO
Glaucoma	☐YES	☐NO
Retinal Conditions (*Macular Degeneration, Tear, Hole*)	☐YES	☐NO
Arthritis	☐YES	☐NO
Cancer	☐YES	☐NO
Diabetes	☐YES	☐NO
Heart Attacks	☐YES	☐NO
High Blood Pressure	☐YES	☐NO
Stroke	☐YES	☐NO
Thyroid	☐YES	☐NO

Allergies to Medications (*Please list.*) _____

Current Medications (*Please list.*) _____

Non-Medication Allergies (*Please list.*) _____

Social History

Education Level ☐High School Graduate ☐College Graduate ☐Other: _____

Do you drink alcohol? ☐YES ☐NO How often? _____ Do you smoke? ☐YES ☐NO How many packs per day?___

Patient's Signature: _____ Date: _____

☐History Reviewed Doctor's Signature: _____ Date: _____

Lifestyle Questions

Do you work at a computer? ☐YES ☐NO If *"YES"*, how many hours before eye fatigue starts? _____

What intensity of light do you typically work in? ☐Bright Light ☐Medium Light ☐Low Light

(*Below please check all that apply to you.*)

- ☐ Glare bothers me while I'm at my computer and/or while night driving.
- ☐ I currently have prescription sun wear.
- ☐ I prefer not to wear my glasses at times.
- ☐ I have more than one pair of prescription glasses.
- ☐ I am interested in non-surgical vision correction.
- ☐ I am interested in Laser Vision Correction
- ☐ I am interested in "test driving" the latest contact lens designs.
- ☐ I have special eyewear needs (driving, sport, safety, reading, fashion frames, colored contact lenses.)
- ☐ I think I might benefit from thinner, lighter lenses.

Insurance and Patient Billing Information

Please note that insurance does NOT cover the Contact Lens Follow-up Evaluation

RESPONSIBLE PARTY (*Parent or Guardian if child, or Spouse*)

Name: _____ D.O.B. _____ Social Security# _____

VISION INSURANCE COMPANY

Social Security#/ID# _____

PRIMARY MAJOR MEDICAL INSURANCE

Policyholder's Name _____ D.O.B. _____

Social Security#/ID# _____

SECONDARY MAJOR MEDICAL INSURANCE

Policyholder's Name _____ D.O.B. _____

Social Security#/ID# _____

(*Your initials*) _____ ***I acknowledge receiving Quality Family Eyecare HIPPA Policy Statement***

AUTHORIZATION FOR TREATMENT/ BENEFIT ASSIGNMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that the payment of benefits be made to the provider on my behalf. I understand that it is my responsibility to pay for services, deductibles and materials which I have ordered, but which are not covered by my insurance company. I understand that a finance charge of 1.5% per month will be added to any unpaid balance on my account over thirty (30) days.

Signature (*Guardian, if minor*) _____ Date _____

AUTHORIZATION FOR PAYMENT: I request that payment of authorized Medicare/and or any insurance(s) benefits be made either to me or on my behalf to Dr. Jackson and/or Dr. Needham (Quality Family Eyecare, Inc.) for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits.

Signature _____ Date _____