WOODBRIDGE FAMILY EYE CARE

Personal Information

Last Name: _____ First Name: _____ DOB: _____/_____/_____ Gender: M / F

(If patient is a minor, name of parent or guardian): _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Email: _____

Occupation: _____ Primary Care Physician: _____ Previous Eye Dr: _____

How did you hear about us? Google Sign On Building Social Media Friend/Family (if so, who): _____

Personal History

What is the reason for today's exam? Update Glasses Prescription Update Contact Prescription First Eye Exam

Other: _____

Year of last eye exam: _____ Age of current glasses: _____

Do you currently wear contacts? YES NO If yes, what kind are they? SOFT or HARD

Are you interested in trying contacts today? YES NO

Personal Medical History: Circle ALL that apply

Allergies/Immunologic:	seasonal, medical, environmental, lupus, Sjogren's syndrome
Cardiovascular:	high blood pressure, high cholesterol, heart disease, congestive heart failure
Ear/Nose/Throat:	hearing loss, dry mouth, vertigo, sinus conditions
Endocrine:	thyroid dysfunction, Type 1 Diabetes, Type 2 Diabetes (current A1c level: _____)
Hematologic/Lymphatic:	anemia, bleeding problems, HIV/AIDS
Integumentary (skin):	eczema, rosacea, psoriasis, shingles, skin cancer
Musculoskeletal:	arthritis, fibromyalgia, muscular dystrophy
Neurological:	multiple sclerosis, epilepsy, stroke, migraines, frequent headaches
Pregnant or Nursing:	pregnant, nursing
Psychiatric:	depression, anxiety, ADHD
Respiratory:	emphysema, COPD, sleep apnea, asthma
Other Conditions:	_____

I have NO medical conditions to report

Medications: List all including over the counter, vitamins, and supplements _____

_____

Allergies: List allergies to all medications _____

Surgical History: List all previous surgeries _____

Personal Eye History: Have you ever been diagnosed or treated for any of the following? Circle ALL that apply

Lazy Eye (Amblyopia) Dry Eye Cataracts Glaucoma Retinal Disease Retinal Detachment Macular Degeneration
Wandering Eye (Strabismus) Iritis/Uveitis Floaters Flashes of Light Double Vision Eye Injury Eye Infection
Keratoconus NONE Other: _____ List all previous eye surgeries: _____

Family History: Circle ALL that apply

Glaucoma Macular Degeneration Retinal Disease Blindness Cataracts Diabetes Other: _____
Please indicated which family member: _____

Social History: Do you use tobacco products? CURRENTLY PREVIOUSLY NEVER Alcohol? YES NO Frequency: _____

Financial Information

Who is financially responsible for the account? _____ Relationship to patient: Self / Spouse / Guardian
Bill my insurance (Name of insurance: _____) OR I am paying out-of-pocket
Insurance Policy Holder's Name: _____ DOB: _____/_____/_____ Last 4 Digits SS#: _____

Our optometrists perform both routine eye exams for glasses and contacts, as well as medical eye exams. Should your exam include additional testing and treatment for a medical eye condition (ex: dry eye, diabetes, ocular allergies, glaucoma, etc.), your medical insurance may be billed. Please let our staff know if you have any questions regarding this policy.

I understand that information obtained from my insurance plan on my behalf is not a guarantee of payment or benefits, and I am obligated to pay any portion of office fees (exam and materials) not covered by my insurance company.

I acknowledge that I am financially responsible for any balances due on this account. I am aware that any unpaid balances will be turned over to collections and that I am responsible for any fees associated with this. I authorize Woodbridge Family Eye Care or the insurance company to release any information required for this claim.

***Initial Here: _____

HIPPA Privacy Policy

Woodbridge Family Eye Care will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. A detailed privacy statement can be provided upon request. Federal Law requires that you be made aware of your privacy rights regarding your personal medical information.

*****Initial Here:** _____

Glasses and Contact Lens Prescription Policies

Glasses Patients

Glasses prescriptions are guaranteed for **90 days** from the date of the exam. **Any changes to the prescription occurring after the 90 days from the date of exam will incur an office visit fee.**

Contact Lens Patients

First time contact lens wearers must complete a staff led contact lens training prior to release of trial lenses. All contact lens prescriptions require follow-up care prior to the release of the prescription. You are responsible for following through with your follow-up appointment. **Your contact lens exam fee includes follow-up care for the 90 days following the initial exam. Any changes made after the 90 day period will incur an office visit fee. Any changes made after 6 months will require another exam and fitting.**

By signing below, I have read and agree to all the above stated office policies and verify that my medical history is up to date and accurate.

Signature: _____ **Date:** _____

If patient is a minor, print parent/guardian name: _____

For future use: Do not sign until instructed

All above medical information is accurate and up to date **Initial and Date:** _____ **Initial and Date:** _____

Some above medical information has changed since my last visit **Initial and Date:** _____ **Initial and Date:** _____