Family Eye Care
Patient Information

Name: _____ Sex: M F Date of Birth: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____ ☐ I receive mail here

Name of Guarantor/Parent if under 18: _____ Patient Soc. Sec. #: _____-_____-_____

Home Phone: _____ Daytime/Work Phone: _____ Cell Phone: _____

Email: _____ Employer: _____ Occupation: _____

Preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Postal Mail

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Other

Employment Status: ☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Retired ☐ Student FT ☐ Student PT

How Did You Hear About Our Office? _____

Insurance Information

It is your responsibility to know the terms and limitation of your policies. Failure to inform us of all of your insurance information may result in a denial of benefits and payment in full being owed by you. Please provide us with all of your insurance information. Your carrier is required to respond to our claim submission within 30 days. If we receive no response from your insurance company we may ask you to contact your insurance company or remit payment yourself and seek reimbursement from your insurance company. ***Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed.*** When a medical condition is present (diabetes, high blood pressure, dry eyes, red eyes, allergies, etc.) it is necessary to file the claim with your major medical carrier. Vision plans do not typically cover medical problems, just as medical insurance does not cover routine glasses and contact lens exams. ***We are often unable to bill your vision plan for the glasses/contact lens portion of your exam on the same day we bill your medical insurance for management of your medical eye problem. Our office does not make these rules, they are defined by the insurance carriers themselves.*** We will need copies of your insurance cards and a photo ID

Primary Medical Insurance

Carrier (circle): Medicare Aetna BC/BS Cigna United Health Care Other _____

ID#: _____ Group #: _____

Policy Holder (PH) Information (complete only if you are not the primary policy holder)

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: _____-_____-_____

Secondary Medical Insurance

Carrier (circle): Medicare Aetna BC/BS Cigna United Health Care Other _____

ID#: _____ Group #: _____

Policy Holder (PH) Information (complete only if you are not the primary policy holder)

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: _____-_____-_____

Vision Plan Information

Carrier (circle): VSP EyeMed Community Eye Care Other _____

ID#: _____

Policy Holder (PH) Information (complete only if you are not the primary policy holder)

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: _____-_____-_____

Dr. Yvonne T. Shook *may use my health information and may disclose such information to the above-named Insurance. Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Please provide your insurance card(s) and a valid form of picture identification with this form at check in.*

Patient Signature (or parent/guardian if under 18): _____ Date: _____

Payment for Services: I agree to pay all charges for services and materials at the time of my first visit, or half the charges for materials upon order and the balance upon delivery for glasses or contact lenses.

Method of payment today: Cash_____ Check_____ MC/Visa_____

Debit Card_____

Welcome to the Family Eye Care
Patient Ocular and Medical History

Patient Name:_____ **Date:** _____

Have you ever had any of the following eye problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Headaches	☐	☐	☐	Eye strain	☐	☐	☐
Flashes	☐	☐	☐	Blurred Vision	☐	☐	☐
Floaters	☐	☐	☐	Sandiness/Grittiness	☐	☐	☐
Itching	☐	☐	☐	Dryness	☐	☐	☐
Tearing	☐	☐	☐	Halos	☐	☐	☐
Burning	☐	☐	☐	Discharge	☐	☐	☐
Double Vision	☐	☐	☐	Eye Injury	☐	☐	☐
Light Sensitivity	☐	☐	☐	Eye Surgery	☐	☐	☐
Redness	☐	☐	☐	Other_____	☐	☐	☐

Have you ever been treated for the following?

Ocular Condition	No	Yes	Current	Medical Condition	No	Yes	Current
Cataracts	☐	☐	☐	Lazy Eye	☐	☐	☐
Crossed Eye	☐	☐	☐	Macular Degeneration	☐	☐	☐
Glaucoma	☐	☐	☐	Retinal Detachment	☐	☐	☐
Lasik/RK	☐	☐	☐	Other_____	☐	☐	☐

Please list all of your medications, including birth control and over the counter medications/vitamins: _____

_____

_____

Please briefly explain your reason for today's visit: _____

_____

_____

Please list any drug allergies: _____

_____

_____

Current Contact Lens Wearers: ☐ Need lenses ☐ Do not need lenses **Non Contact Wearers**: ☐ Interested ☐ Not interested

Pretesting

Dr. Shook recommends that all adult patients should have their eyes tested for peripheral vision loss using the Zeiss FDT and Nidek Digital Camera. The purpose is to better diagnose and treat diseases like glaucoma. Because most insurance plans consider this above and beyond the standard of care for routine eye exams, there will be a $39.00 charge.
This fee is in addition to any medical or vision exam co-payments. If you do not agree to this, please tell the technician prior to the actual testing.