

Welcome to Our Office

The Doctors and staff are pleased to welcome you to U & M Family Eyecare P.C. Please take a few minutes to fill out this form as completely as you can. If you have any questions, it will be our pleasure to assist you. We look forward to working with you in maintaining your visual health.

PATIENT INFORMATION

Patient Name: _____ Date _____
Address _____ City _____ State _____ Zip _____
Mailing Address (if different) _____ City _____ State _____ Zip _____
Home Phone _____ Work # _____ Cell # _____
E-Mail Address _____ Birthdate _____ Age _____ M F
Guardian (if patient is a minor) _____ Occupation _____ SSN _____

REASON FOR VISITING OUR OFFICE TODAY (please check all that apply)

<input type="checkbox"/> Blurred Vision At: <input type="checkbox"/> Distance <input type="checkbox"/> Near <input type="checkbox"/> Trouble Seeing at Night <input type="checkbox"/> Headaches <input type="checkbox"/> Computer Eye Strain <input type="checkbox"/> Want/Need Contact Lenses	Type of contact lenses: <input type="checkbox"/> Soft <input type="checkbox"/> Daily Wear <input type="checkbox"/> Extended Wear <input type="checkbox"/> Disposable <input type="checkbox"/> Gas Permeable Do you wear CL's now? Y N How long? _____ Are you interested in LASIK? Y N
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MEDICAL HISTORY

Date of Last Eye Exam (approximately) _____

*Have you ever had any eye:

Any family history of:

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|------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Injuries | <input type="checkbox"/> Illnesses/
Diseases | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> NONE | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> NONE |

Do you have any of the following? (check all that apply) <input type="checkbox"/> Arthritis, Rheumatism <input type="checkbox"/> Asthma/Respiratory Disease <input type="checkbox"/> Allergies/ Sinuses <input type="checkbox"/> Back Problems <input type="checkbox"/> Cancer	<input type="checkbox"/> Circulatory Problems/ High Blood Pressure <input type="checkbox"/> Cortisone/Prednisone Treatments <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Pregnancy <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis
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Are you currently taking any medication?: Y N If yes, list the medication: _____

Are you allergic to any medication?: Y N If yes, list the medication: _____

Please put me on your e-mailing list: YES NO

By signing below I acknowledge that:

- The information I have provided is accurate to the best of my knowledge.
- I am financially responsible for all charges incurred today, **including contact lens fees**, if applicable.
- I may request a copy of U & M Family Eyecare, P.C. Notice of Privacy Practices (effective April 14, 2003), although it is posted in the office.
- **ALL EXAMINATION FEES ARE DUE UPON COMPLETION OF SERVICES.**
- PROFESSIONAL FEES ARE **NOT** REFUNDABLE. Contact lens fittings may require a follow-up visit which may be subject to additional fees if the patient fails to return within **30 days** of the initial visit.

Patient/Guardian Signature _____ Date _____

Thank you for the privilege of allowing us to take care of your eye health and vision needs.