Welcome to Advanced Family Eyecare!

Tell us about YOU!

Last Name: _____ Gender: M/F

First Name: _____ Middle Initial: _____ Date of Birth: _____

Title: _____ Suffix: _____ Social Security #:_____

Nickname: _____ Marital Status: Single/Married/Divorced/Widowed

Address: _____ Employer Status: _____

City: _____ Employer: _____

State: _____ Zip Code: _____ Occupation: _____

Home Phone: _____ Preferred Language: _____

Daytime Phone: _____ Race: _____

Cell Phone: _____Text OK? _____ Ethnicity: _____

Email Address: _____

How would you like us to contact you (circle one)? Email Telephone Postal

How did you hear about us? _____

Patient Privacy

- **A copy of our privacy policies is posted in our waiting area and on our website madisoneyes.com. Free copies are available at our front desk. Per HIPAA guidelines, your consent is necessary for our office to discuss your eye care with others except for the exclusions listed in our policies. Please list below those you wish to allow us to discuss your care with.**

    - Name:_____ Relationship:_____
    - Name:_____ Relationship:_____
    - Name:_____ Relationship:_____

Office policies and procedures

- **Our office policies and procedures are available for review at our website *madisoneyes.com* or at our front desk. These policies include but are not limited to: contact lens fitting and refraction fees, eyeglass order policies, insurance filing, late fees for unpaid bills and emergency visit policies. If you have any questions at any time, feel free to ask one of our staff members.**

I acknowledge and accept the office and privacy policies of Advanced Family EyeCare.
I do ◯ I do not ◯ grant this office permission to bill my insurance company for any care I receive. I understand if medical eye conditions are being followed or treated, my medical insurance will be billed. If applicable, I grant permission for the minor under my care to be examined, diagnosed and treated if they are the patient here for care.

Signature _____ Date_____

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Patient Questionnaire

1. Medical Insurance Carrier _____

2. Secondary Medical Carrier _____

3. Preventative Vision care Carrier _____

4. Health history (Circle all that apply):
   a. Diabetes
   b. High Blood pressure
   c. High cholesterol
   d. Cancer
   e. Autoimmune disease (Lupus, Sjogren's, etc)

5. Current medications:
   a. _____
   b. _____
   c. _____
   d. _____

6. Medication allergies
   a. _____
   b. _____
   c. _____
   d. _____

7. Do you smoke? **Y/N** Drink Alcohol? **Y/N** Take Narcotics? **Y/N**

Signature _____ Date_____