



## 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](http://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.

<input type="radio"/> Name: _____	Relationship: _____
<input type="radio"/> Name: _____	Relationship: _____
<input type="radio"/> Name: _____	Relationship: _____

### Office policies and procedures

- **Our office policies and procedures are available for review at our website [madisoneyes.com](http://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 \_\_\_\_\_



*Welcome to Advanced Family Eyecare!*

## 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 \_\_\_\_\_