



FAMILY VISION

Welcome to our office

[Please Print]

NAME (last) _____ (first) _____ (m) _____ DATE _____

PARENT/GUARDIAN _____ GENDER M _____ F _____

ADDRESS _____ AGE _____

CITY _____ ST _____ ZIP _____ BIRTHDATE _____

OCCUPATION _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

EMAIL: (may we contact you: Y / N) _____ CELL PHONE _____

REFERRED BY _____ SS# _____

INSURANCE: VISION _____ MEDICAL _____

POLICY HOLDER NAME _____ D.O.B. _____ SS# _____

EYE HEALTH HISTORY Place a mark on "Yes" or "No" to indicate if you have any of the following:

Last Eye Exam _____	Blurred Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
From Dr. _____	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever worn glasses? _____	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? _____	Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye <input type="checkbox"/> Yes <input type="checkbox"/> No
Type? _____	Eye Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degen. <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Infection <input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY Place a mark on "Yes" or "No" to indicate if you have any of the following:

Physician's Name _____	AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	High BI Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone # _____	E.N.T. Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Last Visit _____	Gastro Intestinal <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Condition <input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart Condition <input type="checkbox"/> Yes <input type="checkbox"/> No	Are You Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No

SOCIAL HISTORY Tobacco: Y N Alcohol: Y N Drugs: Y N

FAMILY HISTORY Place a mark on "Yes" or "No" to indicate if they have had any of the following:

Because so many factors affect your eyes, we need to know the following about your blood relatives...

Crossed Eye <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Lazy Eye <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Eye Disease _____

ALL MEDICATIONS (Including Eye Drops)

DRUG ALLERGIES

ADVANCED GLAUCOMA SCREENING

Glaucoma is the leading cause of preventable blindness in the United States and early detection is critical to preserve vision. Family Vision offers advanced Glaucoma screening using two state of the art diagnostic instruments.

The GDX measures the thickness of the retina where glaucoma damage first occurs.

The FDT is a computerized evaluation of your peripheral vision and aides in the detection of glaucoma as well as brain tumors, aneurysms, and strokes.

These screening tests are recommended for all patients 40 years of age or older. These screenings require about 5 minutes of your time at a charge of \$30.00.

These screening tests are NOT covered by insurance.

Yes, I would like the Advanced Glaucoma Screening. No, I decline the Advanced Glaucoma Screening.

DILATION

We may need to install drops to examine the inner wall of your eyes. These drops may cause some sensitivity to light and blurred vision.

- I give permission for the diagnostic drops to be used in my eyes.
- I do not give permission for the diagnostic drops to be used in my eyes.

Patient Signature _____ Date _____

Curington Eye Associates, P.A.

Acknowledgement of receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a Notice of Privacy Practices that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Patient Name: _____
(Signature of Patient or Legal Representative)

Witness

Date