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Falcon Family Eye Care

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Welcome To Our Office!

New Patient Information and Medical History

Patient Demographics:

Last Name _____ First Name _____

Middle Initial ____ Nickname _____

Address _____

City _____ State _____ Zip_____

Home Phone _____ Daytime Phone _____

Cell Phone_____ Texting Ok? Yes ☐ No ☐

Email Address _____

Date of Birth _____ Age ____ Social Security # _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Employer_____ Occupation_____

Preferred Language: English ☐ Spanish ☐ Other_____

Race: ***Please check*** American Indian/Alaskan Native ☐ Asian ☐

Black/African American ☐ Hispanic ☐

Native Hawaiian/Pacific Islander ☐ White ☐

Ethnicity: ***Please check*** Hispanic/Latino ☐

Not Hispanic/Latino ☐

Pacific Islander ☐

Communication Preference: Email ☐ Postal ☐ Telephone ☐

Who may we thank for referring you to our office? How did you hear about us?

Patient Referral _____

Professional Referral _____

Bing ☐ **Drive by** ☐ **Facebook** ☐ **Falcon/Peyton Directory** ☐

Friend of Dr. ☐ **Friend of Staff** ☐ **Google** ☐ **High Plains Little League** ☐

Lions Club ☐ **Insurance Company** ☐ **School Screening** ☐ **InfantSee Program** ☐

Walk-in ☐ **Website** ☐ **New Falcon Herald** ☐ **Ranchland News** ☐

Yellow Pages ☐

Patient Health History:

Primary Care Physician _____

Other Physician _____

Last Vision Exam Date _____ Last Physical Exam Date _____

I have a history of: **Tobacco Use** ☐ **Alcohol Use** ☐ **Narcotic Use** ☐

Glasses History: **Not Applicable** ☐

What type of lenses? Single Vision ☐ Bifocal/Trifocal ☐ Progressive ☐

Are you happy with your current glasses? Yes ☐ No ☐

If no, please describe _____

_____

Contact Lens History: **Not Applicable** ☐

What type of contacts do you wear? RGP ☐ Soft Disposable ☐

Are you happy with your contact lens comfort? Yes ☐ No ☐

If no, please describe _____

_____

Would you like to discuss the option of LASIK surgery? Yes ☐ No ☐

Please list your hobbies/sports: _____

_____

I am currently having problems with: ***(Please check all that apply)***

Blurred Vision at Distance ☐ Blurred Vision at Near ☐ Dry Eyes ☐

Headaches ☐ Eye Strain ☐ Itchy Eyes ☐

Watery Eyes ☐ Floaters ☐ Flashes ☐

Other *(Please Describe)* _____

_____

Do you or any of your relatives have, or have had, any of the following. ***(Please check all that apply)***

Condition/Disease:	**Relationship to you:** ***(Self, mother, brother, etc.)***
Heart Problems ☐	_____
Lung Problems ☐	_____
Diabetes ☐	_____
High Blood Pressure ☐	_____
Thyroid Problems ☐	_____
Glaucoma ☐	_____
Cataracts ☐	_____
Macular Degeneration ☐	_____
Seasonal Allergies ☐	_____
Lazy Eye/Crossed Eye ☐	_____
Blindness ☐	_____
Retinal Detachment ☐	_____
Arthritis ☐	_____

Other: *(Please Describe)* _____

_____

Please list any medications you are currently taking: _____

_____

Please list any drug allergies: _____

Insurance Information:

Insurance Name _____ Insured ID# _____

Plan Name _____ Policy Group _____

Relationship to Insured _____

Type: Medical ☐ Vision ☐

Guarantor/Guardian *(if different from patient)*

Last Name _____ Sex: Male ☐ Female ☐

First Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Daytime phone _____

Social Security_____ Employer _____

Secondary Insurance Information

Insurance Name _____ Insured ID# _____

Plan Name _____ Policy Group _____

Relationship to Insured _____

Type: Medical ☐ Vision ☐

Guarantor/Guardian *(if different from patient)*

Last Name _____ Sex: Male ☐ Female ☐

First Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Daytime phone _____

Social Security_____ Employer _____

Payment Policy:

Payment is expected at the time of service. Insurance billing and insurance payment is based upon individual insurance guidelines. I hereby authorize payment of vision, medical, and surgical benefits directly to Falcon Family Eye Care, LLC I have read and understood that all vision, medical, and surgical charges incurred by myself, or my dependents for services rendered by Falcon Family Eye Care, LLC are my financial responsibility. After 30 days we expect payment in full if your insurance company has not paid. Any balances due will be charged a 1.5% finance charge after 30 days. If the account is referred to a collection agency, I understand that I am responsible for an additional collection fee of 50% of the principal balance plus all reasonable attorneys' fees and all court costs associated with any action brought to enforce this agreement.

Check policy:

If your check is returned for any reason you will be charged a $30.00 processing/service fee.

I have read and agree to the payment and check policy stated above.

Signature_____Date_____

I have read and understand the HIPAA privacy statement provided to me for Falcon Family Eye Care, P.C.

Signature_____Date_____