

# Advanced Family Eyecare, LLC

Welcome to Advanced Family Eyecare, LLC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.

Male  Female

\_\_\_\_\_  
First Name MI Last Name Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

\_\_\_\_\_  
Email Address Guardian Person Responsible for Account

\_\_\_\_\_  
Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book  School  Advertisement  Patient  
 Insurance Listing  Drive by  Other  Doctor

\_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

\_\_\_\_\_

\_\_\_\_\_  
Name and Address of Primary Insurance Company City State Zip

M  F

\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
Insured's Identification Number Group Number

\_\_\_\_\_  
Insured's Date of Birth

### Patient Relationship to Insured

- Self  Spouse  Child  Other

### Patient Status

- Single  Married  Other  
 Full Time Student  Part Time Student  Employed

## SECONDARY INSURANCE INFORMATION

\_\_\_\_\_

\_\_\_\_\_  
Name and Address of Secondary Insurance Company City State Zip

M  F

\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

### Patient Relationship to Insured

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth  Self  Spouse  Child  Other

### Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name **PATIENT HISTORY AND INFORMATION**

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Other Race	<input type="checkbox"/> Refuse To Specify
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Native American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	<input type="checkbox"/> Caucasian	

Other Race

Ethnicity  Hispanic Or Latino  Not Hispanic Or Latino  Unknown

Preferred Language  English  Spanish  French  Italian  Russian  Portuguese

ft	in	cm/m	<input type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight	<input type="text"/>	<input type="radio"/> lbs	<input type="radio"/> kg
<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>		

**PRIMARY CARE PHYSICIAN**

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

**REFERRING PHYSICIAN**

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

**HEALTH HISTORY**

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

When was your last health exam ? \_\_\_\_\_

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_