6035 Airline Drive, Suite 2 Houston, Texas 77076
familyeyecareexperts@gmail.com
P: (281) 849-4844 | F: (281) 849-4866

Patient Intake Form

Patient Information

Today's Date_____

Last Name_____ First Name_____ MI____ Street Address_____

City_____ State_____ Zip Code_____ Home Phone_____

Work Phone_____ Patient's SSN_____ Occupation (Or Grade)_____

Spouse (Or Parent's Name)_____ Date of Birth_____ Age_____ Sex (Circle one) M F

Email Address_____ What is the purpose of this visit?_____

Any problems with your current contact lenses or glasses?_____

_____

The mission of Family Eyecare Experts is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Vision Insurance_____ Subscriber Name_____

Subscriber SSN_____ Subscriber Birth Date _____

Primary Medical Insurance _____ Subscriber Name_____

Subscriber SSN_____ Subscriber Birth Date_____

Do you participate in a Flex Spending Account? (Circle One) Yes No

How will you settle your account today? (Circle One) Cash Check Credit Card

Lifestyle Questions

Do you…(check box if you answer is yes)

☐ …work at a computer? How many hours? _____

☐ …have prescription sunwear?

☐ …prefer not to wear your glasses at times?

☐ …want information on Laser Vision Correction surgery?

☐ …have interest in a non-surgical approach to vision correction?

☐ …have more than 1 pair of current RX eyewear?

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision
☐ Burning
☐ Cataracts
☐ Corneal abrasions
☐ Crossed eye/Eye turn
☐ Double Vision
☐ Eye Infections
☐ Eye Injury
☐ Flash of light
☐ Floaters/Spots
☐ Glaucoma
☐ Grittiness
☐ Headaches
☐ Iritis/Uveitis
☐ Itchiness
☐ Lazy Eye
☐ Macular Degeneration
☐ Occasional dryness
☐ Retinal Detachment
☐ Sunlight Sensitivity
☐ Tearing
☐ Trouble seeing at night
☐ Uncomfortable glasses
☐ Other eye disorders_____

_____

FAMILY EYE CARE EXPERTS

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The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____ Address_____

Date of Last Physical Check-Up_____ CURRENT MEDICATIONS (Rx or Over the Counter – List name of medications including eye drops, vitamins, and/or birth control pills _____

_____

Allergies to medications? (Circle one) Yes No If yes, which medications?_____

Have you had any surgeries? (Circle one) Yes No Please List: _____

Do you use cigarettes/tobacco, alcohol, or other substances? (Circle one) Yes No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Allergies	☐ Arthritis	☐ Blood/Lymph
☐ Bronchitis	☐ Cancer	☐ Cholesterol
☐ Diabetes	☐ Digestive	☐ Ears/Nose/Throat
☐ Endocrine	☐ Eczema/Rashes	☐ Fatigue
☐ Fevers	☐ Genitourinary	☐ High Blood Pressure
☐ Integumentary (Skin)	☐ Kidney	☐ Muscle/Bone
☐ Neurological	☐ Psychological	☐ Respiratory
☐ Sinus	☐ Throat Infections	☐ Thyroid

Patient Eye History

Date of Last Eye Exam_____ By Whom? _____ Have you ever tried contact lenses? (Circle one) Yes No

Do you currently wear contact lenses? (Circle one) Yes No

Are you satisfied with the vision/comfort of your contact lenses? (Circle one) Yes No

Would you prefer clear contact lenses or colored contact lenses? (Circle one) Clear Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following: (If yes, please list Relationship in the blank – Mother's or Father's side)

☐ Blindness_____	☐ Cataracts_____	☐ Corneal Problems_____
☐ Diabetes_____	☐ Glaucoma_____	☐ Heart Disease_____
☐ Lazy Eye_____	☐ Macular Degeneration_____	☐ Retinal Problems_____

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
- If an insurance check is accidentally sent to You instead of to the Practice, you will immediately turn the check over to the Practice.

Signature_____ Today's Date _____