WELCOME

Name_____Date_____
Address: _____
City, State, Zip Code: _____
Date of Birth: _____Home tel. #: _____Work_____
Cell Phone #: _____
Email Adress: _____
Social Security #:_____

Employer: _____Occupation_____
Business Address: _____

Whom may we thank for referring you to us? _____
Emergency Contact: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____
Relationship to patient: _____Tele #:_____
Address: _____

INSURANCE INFORMATION

Name of Insurance: _____
Name of insured: _____Relationship to pt_____
Date of Birth: _____Social Security #_____
Insurance ID #: _____Group #:_____

HEALTH HISTORY

Reason for Exam_____
Date of last exam: _____ Name of eye Doctor _____
Do you or anyone in your immediate family have a history of the following?

___Diabetes ___Blindness ___High blood pressure
___Cataracts ___ Thyroid ___ Turned or lazy eye
___Glaucoma ___ Heart Condition
___Macular Degeneration ___Auto Immune Diseases/other

Please check any of the following conditions that apply to you:

___Frequent headaches __Drug allergies __Pregnant
___Allergies ___Sinus trouble __Smoker
___Given birth in last 3 months

Please list all medications you are currently taking:

_____

Have you had any of the following conditions?

__Eye surgery __Sensitivity to light __Eye infection
__Eye injury __Floaters/flashes __Double vision
__Medical treatment __Poor distance vision __Eye strain
__Severe eye pain __Poor near vision __Eyes burn/itch
__ Eyes watering __Dry eyes __Color deficiency
__Squinting/rubbing __ Twitching lids

Do you currently wear glasses__ ____When do you wear your glasses:

__All the time __Reading, near work __Work, safety
__Distance tasks __Computer work

Other (please explain) _____
Have you ever worn contact lenses ____ Are you interested in wearing contact lenses? ____
Are you interested in Lasik Surgery? ____Are you interested in Orthokeratology (Paragon CRT)?

(Myopia reduction by cornea remolding) _____ .
Do you work at a computer or video display terminal? _____
What hobbies or sports do you participate in _____

AUTHORIZATION

I certify that I have read and understand the above information and to the best of my knowledge the questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. I.N. Fedoriw to release any information including diagnosis and records of treatment and examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance co. to pay directly to Dr. Fedoriw. I understand that my eye care insurance may pay less than the actual bill for materials and services. I agree to be responsible for payment of all services rendered on my behalf or that of my dependants.

*Signature:*_____

Notice of Privacy Practice Receipt

I acknowledge that I was provided with the Notice of Privacy Practice statement of this office. I understand that I may contact the office at any time with questions relating to this Privacy Practice Notice and Privacy Practices in general.

Print Name: _____Date_____
Signature: _____
Relationship (parent, guardian_____

Our goal at Advanced Family Eye care is to provide you with outstanding service in a timely manner. Unfortunately, there are patients that schedule an appointment and fail to keep it (no show) without calling to cancel. This is unfair to patients who could have been seen at this time. Therefore, we have had to adopt the following policy:

There will be a $25.00 fee charged to the patient for failure to cancel an appointment 24 hours in advance.

I have read and understand the above policy.

SIGNATURE_____DATE
WITNESS_____DATE

OCULAR SURFACE QUESTIONAIRE

PATIENT NAME: _____
DATE: _____

DEMOGRAPHIC INFORMATION

1. Please check any that apply to you? Are you:

Female?	☐	Using a computer more than 1 hr a day?	☐
Male?	☐	Reading for more than 1 hour per day?	☐
Over age 40?	☐	A contact lens wearer?	☐
Tobacco user?	☐		
Traveling in airplanes more than twice per month?			☐
Routinely using a ceiling fan in your bedroom?			☐
Getting less than 7 hours of sleep per night in an average week?			☐

Approximately how many glasses of water do you drink per day?

3 or more ☐
Less than 3 ☐

Approximately how many servings of fish do you eat per week?

3 or more ☐
Less than 3 ☐

Do you take omega-3 supplements such as fish oil? Yes ☐ No ☐

Name Brand _____

2. How many medications (different pills) do you currently take?

3 or more ☐
Less than 3 ☐

3. Do you currently take any of the following medications? (Please check all that apply).

Antihistamines	☐	Beta blockers	☐
Anti-depressants	☐	Radiation therapy	☐
Diuretics (LASIK)	☐	Accutane (even previously)	☐
Active bladder therapy	☐	Hormone Replacement therapy	☐

4. Do you use any of the following eye drops? (Please check all that apply).

Glaucoma drops ☐
Allergy drops ☐
Other _____