Patient information	
Name	Date of birth (mm/dd/yyyy)
Address	
City	Zip
Occupation	Employer
Home / Cell phone	Work Phone
Email address	

Any history of:

Self Family
- ☐ ☐ Glaucoma
- ☐ ☐ Cataracts
- ☐ ☐ Diabetes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Macular Degeneration
- ☐ ☐ Heart Problems
- ☐ ☐ Retinal Degeneration
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Condition
- ☐ ☐ Crossed/ Lazy eyes
- ☐ ☐ Asthma/ Allergies
- ☐ ☐ Color Blindness
- ☐ ☐ Arthritis
- ☐ ☐ Tuberculosis
- ☐ ☐ HIV/ Hepatitis
- ☐ ☐ Cancer
- ☐ ☐ Neuromuscular
- ☐ ☐ Blindness

Other_______________

____

____

Please list all:

Medications:__________________

____

____

____

Allergies:____________________

____

Check off all that apply:
- ☐ Blurry distance vision
- ☐ Poor night vision
- ☐ Eye Strain
- ☐ Blurry Near Vision
- ☐ Trouble Reading
- ☐ Itchy Eyes
- ☐ Discharge
- ☐ Watering
- ☐ Pain in the eye
- ☐ Burning eyes
- ☐ Sandy/Dry eyes
- ☐ Red Eyes
- ☐ Glare/Reflections
- ☐ Discomfort in sunlight
- ☐ Double Vision
- ☐ Floaters or spots in vision
- ☐ Flashes of light
- ☐ Eye injury
- ☐ History of wearing an eye patch
- ☐ History of eye surgery
- ☐ Headaches

Are you interested in:
- ☐ New Spectacles
- ☐ Contact Lenses
- ☐ Light weight glasses
- ☐ Anti-Reflective lens
- ☐ Dry Eye therapy
- ☐ Colored contact lens
- ☐ Sunglasses
- ☐ Clip-ons
- ☐ Safety glasses
- ☐ Lasik

How were you referred to us? …
- ☐ family doctor
- ☐ FaceBook
- ☐ insurance company
- ☐ another patient
- ☐ ________________

Social history:
- ☐ Alcohol use
- ☐ Recreational drug use
- ☐ Tobacco use

ACKNOWLEDGEMENT OF PRIVACY PRACTICES and FINANCIAL AGREEMENT

By signing, I agree that I have read, either online or in the office, or had explained to me, Pycraft Family Eye Care's Notice of HIPAA Privacy Practice and agree to continue my care with Pycraft Family Eye Care under said terms. Additionally, I have read and accept the financial statement either online or in the office.

Payment is expected at the time services are rendered, including non-covered portions of insurance. Please note: most policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. While we do call insurance companies to receive benefit information, we cannot guarantee the accuracy of the information provided. ***Please understand that financial responsibility for your account is ultimately yours, not that of your insurance company****. We are pleased to be able to provide the service of filing your insurance and will forward a bill of any unpaid benefits should there be any. Accounts 90 days old are subject to collection fees and will be transferred to the Lazarus collection agency. There will be a service charge of $30.00 on all returned checks. Sale of glasses or contacts is final unless given*

Patient Printed Name: ___________________________________ **DOB** ____________________________________

1) Would you like appointment reminders/order update **texts** → ………….......... **Yes** **No**

2) Would you like appointment reminders/order update **emails** → ……………..... **Yes** **No**

Who is the primary cardholder on your insurance?

Full Name ____ **DOB** ___________________________

Please list anyone authorized to access your personal record set (prescriptions, accounts, medical history etc...)

Name: ______________________________________ **DOB** ____________________ **Relation** ______________________

Name: ______________________________________ **DOB** ____________________ **Relation** ______________________

In order to properly meet Meaningful Use guidelines, we request your assistance in supplying us with the following information
You may skip supplying this information by circling decline here → ………… **DECLINE**

1.) Preferred Language: ____

2.) Race (circle all that apply):

Asian. American Indian/Alaskan Native. Black/African American. Caucasian. Pacific Islander. Other

3.) Ethnicity (circle):

Hispanic/Latino *Not Hispanic/Latino*

I HAVE READ AND UNDERSTAND THE PFEC HIPAA PRIVACY AGREEMENT AND FINANCIAL STATEMENT AND AGREE TO THE TERMS. I AUTHORIZE THE PERSON(S) LISTED TO ACCESS MY DESIGNATED RECORD SET UNLESS OTHERWISE NOTIFIED IN WRITING THAT THEY ARE NO LONGER ALLOWED ACCESS.

I authorize my eye doctor to provide me with a digital copy of my contact lens prescription via email, text, or the online portal at the completion of my contact lens fitting. A glasses prescription will be made available as well. Paper copies available upon request

x____

Patient Signature (*or legal Guardian*) **Date**

____

Relation to patient *(if legal guardian)*