Willis Family Eyecare

Welcome to our Office!

Please complete this form. We may ask you to review this form from time to time to ensure we have the most up to date information.

Patient's full legal name: _____ (Last) _____ (First) _____ (Middle Initial) Date of Birth: Month ___/ Day ___/ Year ___ Sex: M / F

Address: _____ Apt# _____ City/State: _____ Zip: _____

Home Phone: _____ Cell: _____ Office: _____ Email: _____

Preferred Method of Contact: Home /Cell /Office /Email ____ Occupation: _____ Employer: _____

Name of Parent /Spouse: _____ Grade (if student): _____ School Name: _____

Medical & Visual History

Chief Medical Complaint	[] Blurred Vision [] Tearing [] Redness [] Light Flashes [] Floaters [] Double Vision [] Eye Strain/ Fatigue [] Eye Pain [] Itching/ Irritation

Primary Care Physician: _____ Last Eye Doctor: _____ Last Eye Exam: _____

List Medical Conditions: _____

List Medications: _____

List Allergies: _____

Check Medical Conditions that apply to **YOU**: [] Headaches [] Arthritis [] Diabetes
[] Head Trauma [] Allergies [] Cancer [] Seizures []Asthma [] Lung disease
[] HIV/ AIDs [] High Blood Pressure [] Thyroid [] Heart Disease []Blackouts
[] Hepatitis [] Autoimmune Disease [] Other (Please List): _____

Check Eye Conditions that apply to **YOU**:
[] Lazy Eye [] Glaucoma [] Cataract [] Dry Eyes [] Eye Surgery: _____
[] Turned Eye [] Past Eye Injury: _____ [] Retinal Disease: _____

Check Conditions that apply to your **FAMILY**:
[] Cataract [] Glaucoma [] Retinal Disease [] Other (Please List): _____
[] Cancer [] Diabetes [] High Blood Pressure [] Heart Disease _____

Contact Lens History/ Interest*

***THERE IS A SEPARATE CHARGE FOR CONTACT LENS EVALUATION AND FITTING. BY STATE LAW, A PATIENT MUST BE EVALUATED EACH YEAR IN ORDER TO CONTINUE WEARING CONTACT LENSES REGARDLESS OF PRESCRIPTION AND/OR BRAND CHANGE.**

[] I'm interested in seeing clearly without glasses. [] I'm NOT interested in Contact Lenses.
[] I currently wear Contacts. Brand: (if known) _____
Type: [] Rigid Gas Permeable (hard) [] Soft
[] Extended Wear [] Daily Wear [] Bifocal [] Monovision [] Disposables [] Toric/Astigmatism
Replacement: [] Daily [] 2 week [] Monthly [] Yearly [] Other: _____
How did you find out about our office? [] Location [] Insurance [] Mail-out [] Internet [] Newspaper [] Phonebook
[] Direct Referral: Name: _____ [] Other: _____

Insurance Information: Please Completely fill out this section in order for us to obtain benefits and file insurance claims.
Name of Medical Insurance: _____ Type: [] PPO [] HMO* Name of Vision Insurance: _____
*If Medical is an HMO, a referral from your Primary Care Physician is required for insurance to cover certain procedures.

Name of Primary Insured: _____ Primary's Date of Birth: ___/___/___
Primary's Social Security #: _____-____-_____ Sex: M / F

OFFICE POLICY: Please Read and sign at the bottom. Doing so let's us know the patient/guardian has read and understood the office policy terms and conditions, and is authorizing Willis Family Eyecare to provide treatment.

1. All visits to the office are due and payable in full at time of service.
2. Fees paid for services (ex. Examination, contact lens evaluation, etc.) are non-refundable.
3. By authorizing to receive treatment, the patient/guardian is aware that Willis Family Eyecare cannot guarantee payment from their insurance company at this time. If it is determined that the patient is not eligible for services for any reason (i.e. lapse in coverage, exceptions in contract, etc.), I understand that I (the patient) is responsible for payment of all services that were not covered by the insurance company.
4. There is a Re-Stocking Fee for all returned frames, lenses & contacts. Materials must be returned within 30 days from the purchase date. Most frames have a One Year Warranty for defects by the Manufacturer only. Warranty is voided if the frame is discontinued. Only one remake of lenses is allowed within 60 Days from the Date of Purchase. All other remakes will be at full charge to patient.

Authorization for Treatment: _____ ___/___/___
Signature of Patient/ Guardian **Date**