TALLMADGE FAMILY EYE CARE

PATIENT INFORMATION

Patient's Last Name:	First: MI: Nickname:		
Home Address:	City, State, Zip:		
Phone: (check preferred) ❑ Home: ❑ Cell: ❑ Work:			
Email Address:	DOB:	Sex: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Other
Billing Address (if different):			
SSN:	Employer/School: Occupation/Grade:		
Parent's/guardian's name if patient is a minor:	In case of emergency, we may contact: Relationship to patient: Phone:		
Why did you choose TFEC? ❑ Website ❑ Location ❑ Google ❑ Insurance ❑ Other: ❑ Referred by:			
Race: ❑ Asian ❑ Black/African American ❑ Pacific Islander ❑ Native American/Alaskan ❑ White ❑ Decline			
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Decline	Preferred Language: ❑ English ❑ Spanish ❑ Other:		

INSURANCE INFORMATION

Please note: Most vision plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems such as conjunctivitis, dry eyes, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss, or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, not your vision plan. Some Well Vision plans will apply your benefits toward medical copay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before you schedule your appointment. Insurance benefits quoted during your visit are not a guarantee of coverage.

Medical insurance:	Member ID #:	Policy/Group #:

If the patient is NOT the primary insured, please fill out the following information for the insured:

Name:	DOB:	SSN:	Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Address (if different):	Phone:		

Vision plan:	Member ID #:	Policy/Group #:

If the patient is NOT the primary insured, please fill out the following information for the insured:

Name:	DOB:	SSN:	Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Address (if different):	Phone:		

MEDICAL HISTORY

Primary Physician:	Physician's Phone Number:

When was your last eye exam?	Previous eye doctor:	Name and location of your pharmacy:

Do you live alone? ❑ Yes ❑ No ❑ Assisted Living ❑ Nursing Home	Check if applicable: ❑ I am pregnant ❑ I am nursing

Smoking history: ❑ Never ❑ Former Smoker ❑Some days ❑ Every day	Alcohol use: ❑ None ❑ Occasional ❑ Social ❑ 1 drink/day ❑ 2+drinks/day

If you are a former smoker, when did you quit?

GENERAL MEDICAL HISTORY Check any conditions that apply: (*If you marked yourself, please include the year you were diagnosed*)

	You	Mom	Dad	Sib	None	Describe
Hypertension	❑	❑	❑	❑	❑	
Cardiovascular disease	❑	❑	❑	❑	❑	
Cancer	❑	❑	❑	❑	❑	
Diabetes	❑	❑	❑	❑	❑	

If **YOU** are a diabetic, when were you diagnosed?	What was your last A1C level?

PERSONAL MEDICAL HISTORY Check any conditions that may apply: (*If you marked yes please include the year you were diagnosed*)

	Yes	No	Describe		Yes	No	Describe
Liver disease	❑	❑		Kidney Disease	❑	❑	
Herpes simplex/Shingles	❑	❑		Rashes/Hives	❑	❑	
IBS/gastrointestinal issues	❑	❑		AIDs/HIV	❑	❑	
Arthritis	❑	❑		Asthma	❑	❑	
Liver disease	❑	❑		Autoimmune disorder	❑	❑	

Other medical conditions:

List any major injuries and surgeries (*please include estimated date*):

EYE HISTORY Check any conditions that may apply: *(If you marked yourself, please include the year you were diagnosed)*

	You	Mom	Dad	Sib	None	Describe		Yes	No
Glaucoma	❑	❑	❑	❑	❑		Do you wear glasses?	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑		Have you ever been prescribed glasses?	❑	❑
Retinal Detachment	❑	❑	❑	❑	❑		Do you wear contact lenses?	❑	❑
Cataracts	❑	❑	❑	❑	❑		Are you interested in contact lenses?	❑	❑
Amblyopia/Lazy Eye	❑	❑	❑	❑	❑		List any eye injuries:		
Other eye condition	❑	❑	❑	❑	❑		List any eye surgeries:		

Current Medications (including supplements and OTC drugs): *If you brought a list of medications, please give it to us to add to your chart*	Allergies (medications/ seasonal / other) Yes ❑ No ❑ *If yes, please list*