# ATLANTIC FAMILY EYE CARE

## WELCOME TO ATLANTIC FAMILY EYE CARE!

Mr. Mrs. Ms.: _____ Home Tel: (_____) _____ - _____
Address: _____ Work Tel: (_____) _____ - _____
_____ Cell Phone: (_____) _____ - _____
Date of Birth: _____/_____/_____ Employer: _____
Social Security #: _____-_____-_____ Occupation: _____

### OCULAR INFORMATION:

Approximate Date of Last Eye Exam: _____ Where? _____
Reason for Today's Appointment: _____
Do you feel a change in your prescription is necessary to see clearly for:
Distance: ☐ Yes ☐ No Near: ☐ Yes ☐ No
Do you or anyone in your family have:
☐ Glaucoma ☐ Macular Degeneration ☐ Blindness ☐ Diabetes
☐ High Blood Pressure ☐ HIV/AIDS
Have you ever had:
☐ Eye Disease ☐ Eye or Head Injury ☐ Eye Surgery ☐ Eye Turn
☐ Lazy Eye ☐ Headaches If yes, please explain: _____
Primary form of Vision Correction: ☐ Glasses ☐ Contact Lenses ☐ None
Would you be interested in learning more about contact lenses? ☐ Yes ☐ No
Click reasons that apply: ☐ Full Time ☐ Sports ☐ Social ☐ Color
Are you interested in Laser Vision Correction? ☐ Yes ☐ No

### MEDICAL INFORMATION:

Current Medical Conditions: _____
Current Medications: _____
Allergies to Medications: _____
Physician's Name: _____ Last Physical Exam: _____/_____/_____
Do you smoke tobacco products? ☐ Yes ☐ No Do you Consume Alcohol? ☐ Yes ☐ No
How did you hear about our office? _____

### INSURANCE INFORMATION:

Do you have insurance that covers an eye examination? ☐ Yes ☐ No
If yes, please present your card to the receptionist for photocopying.
If no, please check method of payment for today's services: ☐ Cash ☐ Check ☐ Credit Card

I request that payment of authorized Medicare/and or my current insurance benefits may be made on my behalf to Atlantic Family Eye Care Inc., for services furnished to be by Atlantic Family Eye Care. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits or the benefits payable for the related services. I understand my signature requests that payment be made and I authorize the release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or the agency shown. Atlantic Family Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, co-insurance collection fees and non-covered services. Co-insurance and deductible are bases upon the charge determination of the Medicare Carrier and/or current insurance companies.

Patient or Guardian Signature: _____ Date: _____/_____/_____

Thank you for choosing us for your eye care services!!