Advanced Family Eye Care
Eyewear and Contact Lens Center

Dr. Carrie M. Kearns, OD and Staff would like to say

Welcome to Our Office!

Name: _____ Date of Birth: _____

Address: _____ City: _____ State:____ Zip:_____

Home Phone: _____ Cell Phone: _____

Permission to leave a message: Yes/No Email: _____

Social Security Number: _____ Preferred Method of Reminder: _____

Gender: Male/Female/Other Marital Status: Single/Married/Divorced/Widowed

Name of Spouse or Responsible Party & Relationship: _____

Their Address: _____ Their Phone Number: _____

_____ Permission to share information with them: Yes/No

Insurance Information

Medical Insurance: _____ Policy Number: _____

Policy Holder: _____ Policy Holder D.O.B.: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder: _____ Policy Holder D.O.B.: _____

Vision Insurance: _____ Policy Number: _____

Policy Holder: _____ Policy Holder D.O.B.: _____

Primary Physician: _____ Pharmacy: _____

Jobs, Hobbies or Visual Activities: (circle all that apply) Reading/Computer/Golf/Home Workshop

TV/IPad/Fishing/Hunting/Sewing/Gardening/Outside Activities/Swimming/Team Sports/Other: _____

Do you have any interests in: (circle all that apply) Sunglasses/Sport Glasses/Safety Glasses/Computer Glasses

Have you ever worn contacts before? _____

I am interested in: (circle all that apply) Lasik/CRT/Contact Lenses/Contact Lens Test Drive/Other: _____

Do your eyes: (circle all that apply) itch/burn/sting/water/ache/feel gritty/get red/other: _____

Are you bothered by: (circle all that apply) light glare/sunlight/headlights/dim light conditions/other: _____

Are you having specific difficulty with your vision? _____

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Please list current eye medications? _____

Please list your prescription and non-prescription pills, ointments, medications, etc.: _____

_____

_____

Please list any medication allergies or sensitivities: _____

Personal social history: (circle all that apply) smoke/chew tobacco/alcohol Amount Used: _____

Personal eye history: (circle all that apply) injuries/diseases/surgeries/congenital defects Explain: _____

Family eye history: (circle all that apply) cataracts/glaucoma/macular degeneration/lazy eye/color blind/retinal detachment/other: _____

Have you or any of your blood relatives ever had: (circle all that apply)

Allergies:	Me	Relatives	Constitutional:	Me	Relatives	Heart disease:	Me	Relatives
Stomach/Digestive:	Me	Relatives	Kidney-Bladder:	Me	Relatives	Ear/Nose/Throat:	Me	Relatives
Respiratory:	Me	Relatives	Blood-Lymph:	Me	Relatives	Muscle/Joint/Bone:	Me	Relatives
Cancer:	Me	Relatives	Strokes/Seizures:	Me	Relatives	Other Neurological:	Me	Relatives
Psychological:	Me	Relatives	Skin Diseases:	Me	Relatives	Ovarian/Uterine:	Me	Relatives
Breast Disease:	Me	Relatives	Prostate:	Me	Relatives	Diabetes	Me	Relatives

Other: _____

We ask that payment be made on the day of the service, unless prior arrangements have been made. We accept Visa, MasterCard, American Express and Discover. We will submit in-network insurance for you.

I understand this policy as it is described, and accept responsibility for this account:

Signed: _____ Date: _____