ADVANCED FAMILY EYE CARE
Eyewear and Contact Lens Center

Dr. Doran Espe & Dr. Carrie M. Kearns, Optometrist

Welcome to our Office!

Today's Date: _____

Name: _____ Home telephone _____

Mailing Address: _____ Work telephone: _____

Can we leave message at work? Yes / No

City: _____ State: _____ Zip: _____ Date of Birth: _____

Sex: M / F Social Security Number: _____-_____-_____

Marital Status: S / M / D / W E-mail: _____

Name of responsible person or spouse: _____ Relationship: _____

Their address (if different from above): _____ Their telephone (if different from above): _____

Patient (or Father's) Employer: _____ City: _____ Telephone: _____

Spouse (or Mother's) Employer: _____ City: _____ Telephone: _____

INSURANCE:

Primary Medical Insurance: _____ Policy Number: _____ Policy Holder D.O.B.___/___/__

Secondary Medical Insurance: _____ Policy Number: _____ Policy Holder D.O.B.___/___/__

Do you or your spouse have a flexible spending plan or cafeteria plan through an employer? yes or no (circle)

Do you have any special vision insurance plan or benefits? Please list: _____

Who is your primary physician? _____ Pharmacy? _____

Referred by: (circle) Yellow Pages / Office Sign / Newsletter / Here Before / Insurance / Other /
Friend or Relative: (list)_____

Jobs, Hobbies or Visual Activities: (circle) Reading / Computer / Golf / Home Workshop / TV / Fishing / Hunting / Sewing
Gardening / Outside Activities / Swimming / Team Sports / Other: _____

Do you have any special lens interests? (circle) Sunglasses / Sport Glasses / Safety Glasses / Computer Glasses

Have you ever worn contacts before? _____

I am interested in: (circle) Lasik / CRT / Contact Lenses / Contact Lens Test Drive / None of the previous

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

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

Are you having specific difficulty with your vision? _____

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) smoke / chew tobacco / alcohol

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

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

Patient and Family Medical History: Have you or any of your blood relatives ever had: (circle)

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	High Blood Pressure:	me	relatives	Skin Diseases:	me	relatives
Thyroid-Pituitary:	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 Master card, Visa and Discover. We will submit insurance for you. I understand this policy as it is described, and accept responsibility for this account:

Signed: _____ Date: _____

9/05