Susan E. Halstead, ABOC, FNAO
Michael Caruso, OD
Amanda Solar, OD
205 Lake Avenue, Saratoga Springs, NY 12866
518.584.6111 / Fax 518.580.8589
www.familyvisioncarecenter.com

Patient Personal Information

First Name________________________________ MI____

Last Name_______________________________________

Address____

City____

State_______________________ Zip_________________

Date of Birth______/_______/________

Sex: M / F Marital Status: S / M / D / W

Employer____

Occupation____

Home Phone____

Cell Phone____

Work Phone____

Parent/Guardian____

Emergency Contact____

Emergency Phone____

Primary Care Doctor: _______________________________

Pharmacy/Location: ____

E-MAIL & TEXT NOTIFICATIONS!!

On-line Appointment Requests • Text Notifications of Completed Orders • Appointment Confirmations
• Text Message Appointment Reminders • Satisfaction Surveys

Please provide information below so that we are better able to service you and your eye care needs!

Email: ____Cell: ____________________________

Patient Insurance Information: Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child**

Medical Ins. Carrier_________________________________

ID#____

Group #____

Policy Holder's Name________________________________

Policy Holder's DOB _________ / _________ / _________

Policy Holder's SSN ________ - _________ - ___________

(Required for Military/Humana Ins Billing)

Vision Ins. _____________________________________

ID#____

Group # ____

Policy Holder's Name______________________________

Policy Holder's DOB _________ / _________ / _________

Policy Holder's SSN ________ - _________ - ___________

Patient Medical History Name: ____ DOB: ______________________

What is the main purpose of this visit?____________________________________ Year of last eye examination:_______________

Were your eyes dilated at your last exam? □ yes □ no

Have you ever had a dilated exam? □ yes □ no

Are you Pregnant? □ yes □ no

Are you Nursing? □ yes □ no

Are you a Contact Lens Wearer? □ yes □ no

Brand____

Right Eye Rx______________________________________ Left Eye Rx____
(include BC & DIA parameters) (include BC & DIA parameters)

Have you had LASIK/PRK surgery? □ yes □ no

Dr's Name:________________________________

Date of Surgery:____________________________

Are you interested in LASIK? □ yes □ no

List all allergies (environmental or drug): ____

Current medications or supplements: ____

____

Do you have Diabetes? □ yes □ no
□ Type I □ Type II

Year diagnosed: ________________
Last HbA1C: ___________________

Do you/have you ever used tobacco products? □ yes □ no
Type:_______________ Amount:____________ How long?_________

Do you drink alcohol? □ yes □ no
Type:_______________ Amount: ___________ How long? _________

Have you ever been diagnosed/treated for the following?

Cataracts □ yes □ no
Glaucoma □ yes □ no
Macular Degeneration □ yes □ no
Retinal Detachment □ yes □ no
Lazy Eye or Eye Turn □ yes □ no
Eye Injury □ yes □ no
Eye Surgery □ yes □ no

If yes, provide details: ____________________________
____

Do you experience any of the following?

Blurry Vision □ yes □ no
If so: □ distance □ near □ both
Difficulty at computer □ yes □ no
Difficulty driving at night □ yes □ no
Dry Eye □ yes □ no
Headaches □ yes □ no
Double Vision □ yes □ no
Flashes of Light □ yes □ no
Persistent Floaters □ yes □ no
Eye Itching □ yes □ no
Eye Tearing □ yes □ no

Have you ever been diagnosed or treated for any of the following problems? *Explanation of Problem*

Problem	yes	no	Explanation of Problem
Endocrine (thyroid, hormones, glands)	□ yes	□ no	______________________
Cardiovascular (heart, blood vessels)	□ yes	□ no	______________________
High Blood Pressure	□ yes	□ no	______________________
Respiratory (lungs, breathing)	□ yes	□ no	______________________
Gastrointestinal (stomach, intestines)	□ yes	□ no	______________________
Musculoskeletal (muscles, joints, arthritis)	□ yes	□ no	______________________
Integument (skin)	□ yes	□ no	______________________
Neurological (migraines, seizures)	□ yes	□ no	______________________
Psychiatric (anxiety, depression, etc)	□ yes	□ no	______________________
Ears, Nose, Mouth, Throat	□ yes	□ no	______________________
Hematologic/Lymphatic (anemia, etc)	□ yes	□ no	______________________
Allergic/Immunologic	□ yes	□ no	______________________
HIV/AIDS	□ yes	□ no	______________________

Do you have a family medical history of any of the following:

Glaucoma □ yes □ no Relationship: ____ (Maternal / Paternal)

Lazy Eye □ yes □ no Relationship: ____ (Maternal / Paternal)

Macular Degeneration □ yes □ no Relationship: ____ (Maternal / Paternal)

Color Blindness □ yes □ no Relationship: ____ (Maternal / Paternal)

Other Vision History ____

Preferred Language:

- □ English
- □ Spanish

Race*: (Please indicate all that apply below)*

- □ White
- □ American Indian or Alaskan Native
- □ Asian
- □ African American
- □ Hispanic
- □ Native Hawaiian or Pacific Islander

Ethnicity:

- □ Not Hispanic or Latino
- □ Native Hawaiian/ Other Pacific Islander

Communication Preference:

- □ Email
- □ Text
- □ Mail
- □ Telephone

Referred by: □ Patient:___________________ □ Professional:___________________ □ Other:____________________

Contact Lens Management (for current wearers only): For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and the condition of the eyes while wearing contact lenses. We also evaluate changes in prescription and lens design during this process. **Soft contact lens evaluation and new prescription is $35; refitting to a new brand of contact lens will cost between $50 and $199, depending on the type of lens being fit. The fees for Custom or RGP contact lens evaluations and refits vary. Please ask the Staff or your Optometrist for details.**

Financial Responsibility & Benefits Coverage

I understand that the doctor(s) may or may not be participating with my insurance carrier and I am fiscally responsible for all charges whether or not paid by my insurance company. I give my permission to bill my insurance company with the understanding that I am responsible for all charges whether or not paid by my insurance carrier. I understand that I am responsible for and aware of my eyewear benefits coverage and it is my responsibility to make that information known at time of purchase. I understand that I will forfeit such benefits if they are provided after merchandise has been completed and/or provided. I understand that **the fee for returned checks is $50.00, and the fee for a missed or cancelled appointment without 24-hour notice is $50.00.**

Please sign below that you have reviewed all of the information above and it is correct to the best of your knowledge.

Signature_______________________________ **Printed Name**________________________________ **Date**____________________

(Required)