Family Vision of Anderson,

Williamston and Clemson

 Welcome To Our Office

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take just a moment to update your families or your own patient information. We now utilize the E-Mail and (or) texting to notify you of upcoming appointments, Eyewear and (or) Contacts are ready to pick up. Thank You

Dr. R Baughman, Dr. Graves, Dr. Blaettler

Dr. N Baughman, Dr. Moss and Dr. Morris

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name Mi. Last Name Preferred Nam

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Street Address City State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number Date of Birth Home Phone (w) area code Day Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell Phone E-Mail Address Person Responsible for Account

Patient’s Status

( ) Single ( ) Married ( ) Employed ( ) Full Time Student ( ) Part Time Student ( ) Other

 How were you referred to our office?

( ) Family or Friend ( ) Insurance co. ( ) Job ( ) Previous Patient ( ) Phone Book ( ) Internet

PRIMARY INSURANCE INFORMATION

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Primary Insurance Name of Vision Insurance Any Supplementary Insurance

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Insured’s Identification Number Insured’s Identification Number Identification Number

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Group Number Group Number Group Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Relationship

Please Read:

I assign all of my medical benefits to Family Vision and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I understand that if some fees are not paid by my insurance that I am responsible and will be billed for them. Accounts 90 days old are subject to collections and there will be a service charge for all bounced checks. All co-payments, deductibles, and charges for non-covered services are due at the time of service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

I acknowledge that I have read and or received Family Vision’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

I permit Family Vision to communicate and remind me about my heath related issues and appointments by texting & email.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Family Vision

Patient History and Information

RACE:

 ( ) American Indian or Alaska Native ( ) Native Hawaiian or Other Pacific Island

 ( ) Asian ( ) White ( ) Black or African American ( ) Declined to Specify

 ( ) Hispanic or Latino ( ) Other

PREFERRED LANGUAGE:

 ( ) English ( ) Spanish ( ) Chinese ( ) French ( ) German ( ) Other

PRIMARY CARE PHYSICAN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician Phone Number

Are you planning on getting new glasses? \_\_\_\_\_\_ Contacts? \_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY:

What is the main reason for today’s exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last health exam?\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height Weight

Past Illnesses, Injuries or Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Eye Drops:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please bring all Eye Drops to your appointment.

Medicines that cause reactions or sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your current eye Symtoms/problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_ Severity\_\_\_\_\_\_\_\_\_\_\_

What helps give you relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Vision

Medical History Questionnaire

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a computer? ( ) Yes ( ) No How many hours/day?\_\_\_\_\_\_\_\_\_\_\_\_ Distance from computer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drive? ( ) Yes ( ) No Mileage to work each way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have glare problems? ( ) Yes ( ) No Do you have visual difficulty when driving? ( ) Yes ( ) No

Do you have problems with night driving? ( ) Yes ( ) No Do you currently wear glasses? ( ) Yes ( ) No How Long?\_\_\_\_\_\_

Type of glasses ( ) Full Time ( ) Part Time ( ) Distance ( ) Close

Glasses Owned ( ) Single Vision ( ) Multi-focals – ( ) lined or ( ) no-lined Progressives ( ) Backup ( ) Safety ( ) Sports

( ) Computer ( ) Sunglasses

Have you had trouble in the past with glasses? ( ) Yes ( ) No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear sunglasses? ( ) Yes ( ) No Are your sunglasses your current prescription? ( ) Yes ( ) No

SPECIAL EYEWEAR NEEDS:

 ( ) Computer ( special prescriptions, anti-glare, tints or coatings) ( ) Safety Glasses ( gardening, woodworking or welding)

 ( ) Occupational ( mechanics, plumbers, pilots, etc.) ( ) Sports/Hobbies ( racquet sports, motorcycle)

CONTACT LENS HISTORY:

If not a contact lens wearer, are you interested in trying contact lenses at this time? ( ) Yes ( ) No

Have you ever tried to wear contact lenses? ( ) Yes ( ) No Reason for stopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear contact lenses? ( ) Yes ( ) No Since? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type and brand of contact lenses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s wearing time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours/day? \_\_\_\_\_\_\_\_\_ How many days/week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Lens Comfort\_\_\_\_\_\_\_\_\_ Distance Vision\_\_\_\_\_\_\_\_\_\_\_ Near Vision\_\_\_\_\_\_\_\_\_\_\_\_\_

What solutions do you use? Multi-purpose \_\_\_\_\_\_\_\_\_\_\_ Hydrogen Peroxide \_\_\_\_\_\_\_\_\_\_\_\_ Cleaner \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL HISTORY:

Do you use nutritional supplements ( vitamin, etc. )? ( ) Yes ( ) No

Do you engage in regular exercise? ( ) Yes ( ) No

Do you drink alcohol? ( ) Yes ( ) No If Yes, how much/often? ( ) Occasional ( ) 1 per day ( ) 2-3 /day ( ) 4+ /day

Do you smoke? ( ) Yes ( ) No If Yes, how much/often? ( ) Occasional ( ) ½ pack/day ( ) 1 pack/day ( ) 1+ pack/day

 Method of Tobacco Intake: ( ) Smoking ( ) Chewing

 Do you use Illegal Drugs: ( ) Yes ( ) No

HOBBIES/ INTERESTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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EYE HISTORY:

 Glaucoma ( ) Yes ( ) No Cataract ( ) Yes ( ) No

 Headaches ( ) Yes ( ) No Dry Eye Syndrome ( ) Yes ( ) No

 Macular Degeneration ( ) Yes ( ) No Double Vision ( ) Yes ( ) No

 Retinal Detachment ( ) Yes ( ) No Prism Lenses ( ) Yes ( ) No

 Amblyopia(Lazy Eye) ( ) Yes ( ) No Eye Surgery ( ) Yes ( ) No

 Eye Injuries ( ) Yes ( ) No Reason For Surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Risk Medication ( ) Yes ( ) No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL HEALTH CONDITION:

Fever ( ) Yes ( ) No Respiratory (Asthma) ( ) Yes ( ) No Anxiety, Depression ( ) Yes ( ) No

Weight Loss ( ) Yes ( ) No Gastrointestinal ( ) Yes ( ) No Diabetes, Thyroid ( ) Yes ( ) No

Allergies ( ) Yes ( ) No High Blood Pressure ( ) Yes ( ) No Ear, Nose and Throat ( ) Yes ( ) No

Skin ( ) Yes ( ) No Cardiovascular ( Heart) ( ) Yes ( ) No Muscles, Bones and Joints ( ) Yes ( ) No

Cholesterol ( ) Yes ( ) No Genital, Kidney, Bladder ( ) Yes ( ) No Neurological ( ) Yes ( ) No

Pregnant or Nursing ( ) Yes ( ) No

FAMILY HISTORY:

Blindness ( ) Yes ( ) No Cataracts ( ) Yes ( ) No Glaucoma ( ) Yes ( ) No

Eye Tumors ( ) Yes ( ) No Color Blindness ( ) Yes ( ) No Arthritis ( ) Yes ( )No Heart Disease ( ) Yes ( ) No Cancer ( ) Yes ( ) No Diabetic ( ) Yes ( ) No

Kidney Disease ( ) Yes ( ) No Lupus ( ) Yes ( ) No Stroke ( ) Yes ( ) No

Thyroid Disease ( ) Yes ( ) No Lazy Eye ( ) Yes ( ) No Strabismus ( ) Yes ( ) No

High Blood Pressure ( ) Yes ( ) No Retinal Detachment ( ) Yes ( ) No Macular Degeneration ( ) Yes ( ) No

ELECTIVE SCREENING PROCEDURE

In keeping with our mission to provide the latest technology in caring for your eyesight, Your Physician Recommends an elective procedure- retinal imaging screening.

RETINAL IMAGING SCREENING- allows us to detect early signs of diabetic retinopathy, macular degeneration, retinal detachments and other threatening conditions. It adds to the medical record’s written notes, an actual picture that can be viewed in the future.

The cost for the procedure is $18.00. This is an additional out of pocket expense that is not covered by vision or medical insurance. (Please note that if your Optometric physician has diagnosed a medical condition in the past that requires diagnostic testing or documentation, your elective screening may be converted into the complete diagnostic test. The cost is higher for the medically needed complete test and can be filed to your medical insurance which may pay for some or all of the charge.)

Williamston Office only offers a Laser Glaucoma Screening also. You can do both Retinal Imaging and Laser Glaucoma Screening for $30.00.

\_\_\_\_ I elect the $18.00 retinal imaging \_\_\_\_ I elect the $30 technology package for both \_\_\_\_ I elect the $18.00 laser glaucoma \_\_\_\_ I decline these additional services

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 Signature Date