Patient Information

Family Vision Center

Dr.Vadim Guy

1425 Jefferson Rd, Roch. NY 14623
www.RochesterFamilyVision.com

General information

First, Last, MI, Preferred Name _____ ***Date of Birth*** _____

Street Address, City, State, Zip _____

Phone, Type: _____ *Phone 2, Type:* _____

email: _____ @ **gmail.com hotmail.com aol.com rochester.rr.com**

Preferred Contact Method: ***cell phone / email / text / other:*** _____

Patient Social Security #: _____ *NY License #:* _____

Occupation/Employer: _____ ***Retired / Full-time / Part-time***

Marital Status: ***married / single / divorced / legally separated / widowed***

Language, Race, Ethnicity: _____

Emergency Contact Person and Phone: _____

EYE HISTORY

How many hours a day do you spend on tablet/phone/ computer/TV? _____

Have you had any head trauma? *yes* *no*

explain: _____

Interested in New Contact Lenses? *yes* *no*

Interested in New Glasses? *yes* *no*

Interested in Orthokeratology? *yes* *no*

Date of Last Eye Examination: _____

Reason for today's visit? _____

Referred by: _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*no*	*self*	*family*
Color Blindness	*no*	*self*	*family*
Crossed Eye	*no*	*self*	*family*
Glaucoma	*no*	*self*	*family*
LASIK or RK	*no*	*self*	*family*
Lazy Eye	*no*	*self*	*family*
Macular Degeneration	*no*	*self*	*family*
Myopia *(nearsighted)*	*no*	*self*	*family*
Retinal Detachement	*no*	*self*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

□ Blurred vision (near or computer or distance)
□ Burning
□ Discharge
□ Double Vision
□ Dryness
□ Excess Tearing/Water
□ Eye Irritation
□ Eye Pain or soreness
□ Floaters or Spots
□ Halos
□ Headaches
□ Itching
□ Light Flashes
□ Light Sensitivity
□ Redness
□ Sandy or Gritty Feeling
□ Other:

MEDICAL HISTORY

Have you or a family member experience, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*no*	*self*	*family*
Allergies	*no*	*self*	*family*
Arthritis	*no*	*self*	*family*
Asthma	*no*	*self*	*family*
Blood/Lymph Disorder	*no*	*self*	*family*
Cancer: *type* _____	*no*	*self*	*family*
Diabetes *(type 1 or 2)*	*no*	*self*	*family*
Ear, Nose, Throat Cond.	*no*	*self*	*family*
Gastrointestinal Cond.	*no*	*self*	*family*
Heart Disease	*no*	*self*	*family*
High Blood Pressure	*no*	*self*	*family*
High Cholesterol	*no*	*self*	*family*
Kidney Disease	*no*	*self*	*family*
Lupus	*no*	*self*	*family*
Nurological Conditions	*no*	*self*	*family*
Psychiatric Disorder	*no*	*self*	*family*
Seizures	*no*	*self*	*family*
Skin Conditions	*no*	*self*	*family*
Stroke	*no*	*self*	*family*
Thyroid Dysfunction	*no*	*self*	*family*

Medications: *(prescription / OTC / Vitamins / BC)*

Medication Drug Allergies:

□ No Known Drug Allergies

Primary Care Physician: _____

address: _____

Pharmacy:

F: Are you pregnant or nursing?	*yes*	*no*
Do you smoke?	*yes*	*no*
Have you ever smoked?	*yes*	*no*
Do you drink Alcohol?	*rare / social*	*no*

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Insurance Information			
Primary ***Medical*** *Insurance:*		*Primary Member Name:*	
Insurance Member ID#		*Primary Member Date of Birth:*	
Insurance Policy #		*Primary Member Social Security #*	
Relationship to primary member:		*Primary Member Employer:*	
Secondary ***Medical*** *Insurance:*		*Primary Member Name:*	
Insurance Member ID#		*Primary Member Date of Birth:*	
Insurance Policy #		*Primary Member Social Security #*	
Relationship to primary member:		*Primary Member Employer:*	

I understand that I am responsible for my bill & responsible for collection fees, court costs, & reasonable attorney fees to collect unpaid accounts. I understand that fees for services and products are non-refundable.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Family Vision Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

(Check One Please)

- □ I have read or had explained to me Family Vision Center's Notice of Privacy Practice and agree to continue my care with Family Vision Center under said terms.
- □ I was given an opportunity to read Family Vision Center's Notice of Privacy Practices and declined but wish to continue my care with Family Vision Center under the terms of Family Vision Center's privacy policies.
- □ I have read or had explained to me Family Vision Center's Notice of Privacy Practice and do not wish to continue my care with Family Vision Center under said terms.
- □ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient: _____ **Date:** _____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative: _____ ***Relationship to Patient:*** _____