Welcome to Virginia Family Eye Care

Patient's Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Cell Phone _____ **Work Phone** _____

Date of Birth _____ **Have you seen Dr. Azocar at a previous office? Yes / No**

Email _____ **(NO MARKETING)**

☐**Male** ☐**Female** ☐**Prefer to not say** ☐**Married** ☐**Single** ☐**Other** ☐**Child**

Last 4 Digits of Social Security # _____ **Name of Policy Holder** _____

Reason for your visit? _____

Evaluation for contacts today? Yes / No

Allergies to any medications? Yes / No _____

List any medications you are currently taking _____

_____

Medical History					**Ocular History**				
	Self		**Family**			**Self**		**Family**	
Asthma	Yes	No	Yes	No	Eye Surgery	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No	Cataracts	Yes	No	Yes	No
Hypertension	Yes	No	Yes	No	Glaucoma	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Macular Degeneration	Yes	No	Yes	No
High Cholesterol	Yes	No	Yes	No	Lazy Eye	Yes	No	Yes	No
Auto-Immune	Yes	No	Yes	No	**Any other medical or ocular conditions that we should be aware of?**				
Name of Primary Care Physician:									
Do you smoke	Yes	No							

*****please flip this page over and review the other side*****

Welcome to Virginia Family Eye Care

Please note: If you wear contacts there <u>will be a contact lens evaluation fee charged</u> in addition to the routine eye exam fee. This may not be covered by your insurance.

Required by federal law for contact lenses: My glasses and/or contact lens prescription has been made available to me and I acknowledge that I can purchase my contacts anywhere I prefer.

Signature: _____ Date _____
(If under 18, Parent or Guardian's Signature)

Please note VSP and EyeMed charge for remakes of glasses or frame changes and do not allow a cancellation after the order is placed. Lenses and prescription checks are redone one time within a 3 month period, then regular charges apply. I agree to bill my medical insurance and not my vision plan when medical problems are diagnosed and understand a medical copay may be due. If frames or lenses are returned within 60 days, refunds are not given -- we will place a credit on your account less a 10% return fee to use for other purchases.

I authorize payment directly to Virginia Family Eye Care for services rendered. As the responsible party, I authorize the release of any medical records needed to obtain payment from my insurance company. I will be responsible for all costs of collection, including and not limited to collection fees and attorney fees, and court costs. I acknowledge that Virginia Family Eye Care's HIPAA privacy notice has been made available to me. Your information is kept confidential and we comply with the Health Insurance Portability Act. Inactive records are professionally destroyed after 10 years.

Signature: _____ Date _____
(If under 18, Parent or Guardian's Signature)

At Virginia Family Eye Care, we pride ourselves in providing our patients with the best possible care. As part of this, we offer a state-of-the-art Eidon Retinal Imaging Camera. This non-invasive imaging allows us to see a much broader and more detailed view of your retina than is possible without dilation. These photos are valuable in finding and tracking health conditions including glaucoma, macular degeneration, diabetes, hypertension, floaters, and more. We will review your photos with you today and apply them to your medical file for future comparisons.

Yes – I DO want the retinal photo taken, reviewed and saved for yearly comparisons
(A CO PAY OF $39.00 FEE WILL APPLY)

No – I DO NOT want the photo, and understand dilation drops may be needed

Signature: _____ Date _____
(If under 18, Parent or Guardian's Signature)