Patient Information

If you arrive with a medical condition, we may file with your major medical plan rather than your vision plan.

Name ______________________ DOB __________ Age __________

Address ______________________ City __________ State ______ Zip __________

Cell# __________ Home/Alt# __________ SS # __________ Sex __________

Email: ______________________ Employer __________

Parent/Guardian/Emergency Contact ______________________ Phone# __________

* Children ages 15 and under must be accompanied by a parent/guradian. Children 16-18 must have written consent from their parent/guardian.

Payment Policy:

Initial ______ Financial Responsibility: I acknowledge I have read and signed FECG's Financial Responsibility Form

Initial ______ HIPAA Receipt: I acknowledge I have read/received FECG's Notice of Privacy Practices

Insurance Information (Major Medical)

Financially responsible party: ______________________

Insurance Co __________ Member # __________ Group # __________

Primary Insured's Name __________ Insured's DOB __________ Insured's SS# __________

Insurance Information (Vision or Secondary)

Insurance Co __________ Member # __________ Group # __________

Primary Insured's Name __________ Insured's DOB __________ Insured's SS# __________

Medical and Ocular History

Date of last eye exam __________ Date of last medical exam __________ Family Doctor __________

How many hours a day do you spend on a device? ______ Do you wear glasses? Y ☐ N ☐ Are you interested in refractive surgery? Y ☐ N ☐

Do you wear contact lenses? Y ☐ N ☐ Brand __________ Are you interested in contact lenses? Y ☐ N ☐

Major Surgeries __________ Allergies Y ☐ N ☐ Explain __________

Medications you are currently taking (including OTC) ______________________

Do you or any family member have a history of the following:

Eyes	NO	YES Self	YES Family	**Eyes Cont:**	NO	YES Self	YES Family	**Eyes Cont:**	NO	YES Self	YES Family	**Other**	NO	YES Self	YES Family
Blindness	☐	☐	☐	Dry eyes	☐	☐	☐	Halos	☐	☐	☐	Cancer	☐	☐	☐
Blurred vision	☐	☐	☐	Excessive Tearing	☐	☐	☐	Loss of vision	☐	☐	☐	Diabetes	☐	☐	☐
Burning/Itching	☐	☐	☐	Eye Allergies	☐	☐	☐	Macular Degeneration	☐	☐	☐	Headaches	☐	☐	☐
Cataracts	☐	☐	☐	Eye Pain/Soreness	☐	☐	☐	Mucous discharge	☐	☐	☐	Heart Diseases	☐	☐	☐
Chronic eye infections	☐	☐	☐	Flashes/Floaters	☐	☐	☐	Red eyes	☐	☐	☐	High Blood Pressure	☐	☐	☐
Crossed eyes	☐	☐	☐	Glare/Light sensitivity	☐	☐	☐	Retinal detachment	☐	☐	☐				
Double Vision	☐	☐	☐	Glaucoma	☐	☐	☐	Retinal Problems	☐	☐	☐				

Medical History Required by your Insurance Carrier(s)

	NO	YES Self	YES Family		NO	YES Self	YES Family		NO	YES Self	YES Family		NO	YES Self	YES Family
Musculoskeletal				**Respiratory**				**Neurological**				**Gastrointestinal**			
Arthritis	☐	☐	☐	Chronic Bronchitis	☐	☐	☐	Seizures	☐	☐	☐	Ulcers	☐	☐	☐
Joint pain	☐	☐	☐	Emphysema	☐	☐	☐	Headache(s)	☐	☐	☐	Other	☐	☐	☐
Allergic/Immunologic				**Hematologic/Lymphatic**				Other	☐	☐	☐	**Endocrine**			
Hay Fever	☐	☐	☐	Anemia	☐	☐	☐	**Ears, Nose, Mouth, Throat**				Thyroid problems	☐	☐	☐
Medicine Allergies	☐	☐	☐	Bleeding Problems	☐	☐	☐	Sinus problems	☐	☐	☐	Other glands	☐	☐	☐
Systemic Allergies	☐	☐	☐	Swelling	☐	☐	☐	Chronic cough	☐	☐	☐	**Constitutional**			
Genitourinary				**Cardiovascular**				Dry mouth/Throat	☐	☐	☐	Fever	☐	☐	☐
Kidneys	☐	☐	☐	Heart Problems	☐	☐	☐	Chronic ear infections	☐	☐	☐	Weight changes	☐	☐	☐
Bladder	☐	☐	☐	Vascular disease	☐	☐	☐	**Psychiatric**	☐	☐	☐				

Have you ever been exposed to or infected with: Gonorrhea, Hepatitis, HIV, Syphilis, Chlamydia Y ☐ N ☐ __________

Comments on any Medical Condition: ______________________

Do you use smoke/drink? Y ☐ N ☐ If yes, type, amount and how long? __________

I hereby authorize FECG to release any medical or incidental information that may be necessary for medical benefit or in processing applications for submissions to my insurance company. I understand I am responsible for payment of all charges. As a courtsey, my insurance may be billed for me. It is my responsibility to pay any deductible, copay, or any balance not paid by my inurance carrier. I understand professional fees are non-refundable.

VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.

Signature: ______________________ Date: __________

Must be signed by Parent/Guardian if the patient is under 18 years of age.