PATIENT INFORMATION

Today's Date:_____ Please Circle: Mr./ Mrs./ Ms./ Miss./ Dr./Single/ Married /Other

NAME:_____ AGE:_____DATE OF BIRTH:_____/_____/_____ SEX:_____

SOCIAL SECURITY#:_____

ADDRESS:_____CITY:_____

STATE::_____ZIP: _____EMAIL:*_____

BY PROVIDING EMAIL ADDRESS, YOU ARE AUTHORIZING TO RECEIVE CORRESPONDENCE FROM OUR OFFICE.

HOME PHONE:_____ WORK/CELL: _____

HOW DID YOU HEAR ABOUT US:_____

REASON FOR TODAY'S VISIT: _____

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INSURANCE INFORMATION

INSURANCE COMPANY NAME:_____

POLICY HOLDER'S NAME: _____POLICY HOLDER'S SS#:_____

DATE OF BIRTH:_____ POLICY/ID #:_____

RELATIONSHIP TO PATIENT: SELF/ SPOUSE/ CHILD/ FULL TIME STUDENT/ DEPENDENT/ DOMESTIC PARTNER

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1. Occupation:_____
2. Do you wear eye glasses? _____ If no, have you every worn eye glasses? _____ If Yes, are they for:
   Distance _____, near _____, or both_____. Do you see clearly through them? _____
3. Do you, or have you every worn contact lenses? _____ If yes, type:_____ Are they for:
   Distance _____, near _____, or both_____. Do you see clearly through them? _____
4. If you have had any contact lens problems, please list:_____
5. When was your last eye exam? _____
6. Were your current glasses and/or contact lenses prescribed at that time? _____
7. Are you interested in:
   Laser Vision Correction:_____ Ortho-K (Non-surgical Vision Correction):_____
   Prescription Sunglasses:_____ Computer/Work Glasses: _____
   Contact Lenses: Daily _____ Disposable _____Rigid _____ Colored _____ Bifocal _____

I hereby assign the policy rights and benefits to Dr. Douglas M. Lee, and authorize direct payment for professional services and/or optical equipment rendered. I further authorize this office to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balances or copayment or deductibles to the doctor, and if I receive any payments from my insurance company in error, I will sign them directly over to this office.

Patient Signature (Parent if minor):_____Date: _____

Family Vision Center
Dr. Douglas M. Lee
1734 Lincoln Highway
Edison, NJ 08817

I, _____ hereby acknowledge receipt **of Family Vision Center's Notice of Privacy Practice** on behalf of myself and my dependent(s).

Dependent's Name:	Date of Birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature Date

MEDICAL HISTORY

Name:_____ Date:_____

	Self	Family
High blood pressure	_____	_____
Arthritis	_____	_____
Eye infections	_____	_____
Headaches	_____	_____
Lazy Eye	_____	_____
Double Vision	_____	_____
Cataracts	_____	_____
Eye surgery	_____	_____
Recent weight loss/gain	_____	_____
Eye pain	_____	_____
Allergies (food and /or medication	_____	_____
Heart Condition	_____	_____
Diabetes	_____	_____
Glaucoma	_____	_____
Amblyopia	_____	_____
Eye turn	_____	_____
Smoking	_____	_____
Alcohol use	_____	_____
Colored rings around lights	_____	_____
Unusual sensitivity to lights	_____	_____
Flashes or floaters	_____	_____
Other	_____	_____

Please explan:_____

- Are you currently under the care of a physician for any health problems?
- Have you ever suffered a serious illness? _____ If yes, explain:_____
- Are you currently taking any medication?_____ If yes, please list: _____

_____