Family Vision Care of Bountiful

Dr. Daniel W. Pace

Dr. Adam B. Rudd

Today's Date:_____ Date of Birth:_____ Age:_____ q Male q Female

Last Name:_____ First Name:_____ MI:_____

Address:_____ Cell Phone:_____ Texting Ok q

City:_____ State:_____ Zip:_____ Home Phone:_____

Occupation:_____ E-Mail:_____

Emergency Contact:_____

Who May We Thank for Referring You to Our Office:_____

Family Members at your residence:

Name:_____ age:_____ Name:_____ age:_____

Name:_____ age:_____ Name:_____ age:_____

Name:_____ age:_____ Name:_____ age:_____

Insurance Information... Please provide your card to the front desk and the following info on the Policy Holder:

Name:_____ Date of Birth:_____ Last 4 of SSN:_____

What is the Primary Reason for Your Visit to Our Office Today:_____

Are You Interested In: (Circle all that apply)

Contact Lenses	Bifocal Contact Lenses	Rx Sunglasses	No-Line Bifocals	UV Protection
Anti-Glare Lenses	Computer Specific Rx	Sports Eyewear	Safety Eyewear	Lasik Surgery

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Eye / Visual History

Date of Last Eye Exam:_____ Where:_____

Do You Wear Glasses? q Yes q No If yes, when: q Full Time q Distance q Near

Do you Wear Contacts? q Yes q No What type? q Soft q Gas Permeable q Toric q Bifocal

Do you have (or have you ever had) any of the following eye or vision problems? (Circle all that apply)

Blurry Vision	Eye Infections	Flashes of Light	Itchy Eyes
Crossed or Lazy Eye	Eye Injuries	Floaters in Vision	Sensitivity to Light
Double Vision	Eye Surgery	Headaches	Tired / Irritated Eyes

Personal Medical History

How Would You Rate Your Health in General? q Excellent q Good q Fair q Poor

Date of Last Medical Exam _____ Name of Family Doctor _____

Please List All Medications You Are Taking _____

_____

Do You Have Any Allergies? q Seasonal q Sulfa q Penicillin q Others _____

Do You Use Tobacco? q Yes q No Alcohol? q Yes q No

Do You Have Any Problems with Any of These Body Systems? (Circle Any That Apply)

Gastrointestinal Nervous Psychiatric Ears / Nose / Throat
Genitourinary Blood / Lymph Endocrine (glands) Cardiovascular
Musculoskeletal Integumentary (skin) Respiratory Immunologic (allergic)

Please Explain any "Yes" Answers _____

_____

Family History

Does Your Family Have a History of the Following Problems?

Diabetes	q Yes q No	Glaucoma	q Yes q No
High Blood Pressure	q Yes q No	Retinal Detachment	q Yes q No
Thyroid Problems	q Yes q No	Cataracts	q Yes q No
Vision Loss	q Yes q No	Macular Degeneration	q Yes q No

Other Eye or Medical Conditions? _____

_____

I certify that I have read, understand, and have accurately answered the above information to the best of my knowledge. I understand that proving incorrect information can be dangerous to my health. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize the eye doctor to release any information including the diagnosis, records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and / or health practitioners. In the event that full payment for charges is not made, I agree to pay all cost of collections, Collection Agency commission, attorney's fees, and interest. I also agree to submit myself to the jurisdiction of the courts of Utah.

Signed by Patient (or Parent if Minor) _____ Date: _____