Advanced Eye Care
3702 High Point Road
Greensboro, NC 27407

Davis Eye Associates
3316 Silas Creek Parkway
Winston-Salem, NC 27103

Family Vision Clinic
4514 Oleander Avenue
Wilmington, NC 28403

Patient Registration Information

Welcome to our practice!! Our goal is to provide our patients with the most state of the art service and best personalized care. We welcome your feedback in your vision and eye healthcare. Please complete this sheet front and back and return to the receptionist. Our staff will ask for a photo ID, vision and medical insurance cards. The information marked with * is collected to comply with federal regulations. Please print legibly.

Name _____ Birthdate* _____ Sex M F SSN _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employed? Y N Occupation/Employer _____

Marital Status: Married Single Preferred Language*: Spanish English Preferred Communication*: Email Phone Postal

Race/Ethnicity*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black orAfrican/American
☐ Hispanic ☐ Hawaiian or Other Pacific Island ☐ White

Vision Insurance _____ Email Address _____

Medical Insurance _____ Secondary Medical Insurance _____

Name/Date of Birth of Policyholder _____

Family Physician/Practice Name _____

I understand and agree that I am financially responsible for any portion of my exam that is not covered by my insurance and will pay the balance at the time of service. I have read all the information on the form and have completed it to the best of my knowledge. I will notify you with any changes to the above information.

Signature _____
Patient or Guardian Date

The following services are offered to provide the highest quality vision care for you.

1. Optomap scanning laser exams are recommended by our physicians. The benefits include a more complete view of the back of the eye with the ability to store digital photos and monitor the health of your eyes yearly. The service is fast, easy and most patients may be able to avoid having their pupils dilated with drops. The fee for this advanced medical service is $35.00.
2. Contact lens fitting may or may not be covered by your insurance policy. If you choose contacts, a service agreement will be reviewed prior to your signature explaining the cost and follow up care.
3. All Medicare plans do not cover refraction which determines your glasses prescription. The fee for this service is $20.00.
4. All Medicare plans do not cover routine yearly eye exams.

Please ask a staff member if you have any questions about these items.

WHY ARE YOU HERE?: _____

_____

Medications: _____

_____

Allergies: _____

_____

_____

Are you Pregnant? Yes No	Do you smoke? Yes No	Alcohol Use? Yes No
Interested in Contacts? Yes No	Worn Before? Yes No	Type/Brand _____
Interested in Orthokeratology? (nearsightedness correction while you sleep) Yes No		

OCULAR SYMPTOMS: Check all that apply.

Blur at near	☐	Floaters	☐	Watering	☐
Blur at computer	☐	Dryness	☐	Redness	☐
Blur at distance	☐	Burning	☐	Double Vision	☐
Flashes	☐	Itching	☐	Eye Pain	☐

OCULAR HISTORY: Check all that apply. **M = mother F = father GM = grandmother GF = grandfather**

	Me	Family	M-F-GM-GF		Me	Family	M-F-GM-GF		Me	Family	M-F-GM-GF
Cataracts	☐	☐	_____	Retinal Detachment	☐	☐	_____	Eye Surgery	☐	☐	_____
Glaucoma	☐	☐	_____	Other Eye Disease	☐	☐	_____	Eye Injury	☐	☐	_____

MEDICAL HISTORY: Check all that apply.

Height_____**Weight** _____

	Me	Family	M-F-GM-GF		Me	Family	M-F-GM-GF		Me	Family	M-F-GM-GF
Cancer	☐	☐	_____	**GASTROINTESTINAL**				**INTEGUMENTARY**			
CARDIOVASCULAR				Acid Reflux	☐	☐	_____	Rosacea	☐	☐	_____
Hypertension	☐	☐	_____	Other	☐	☐	_____	Other	☐	☐	_____
High Cholesterol	☐	☐	_____	**GENITOURINARY**				**MUSCULOSKELETAL**			
Heart Disease	☐	☐	_____	Prostate	☐	☐	_____	Arthritis-Osteo	☐	☐	_____
Other	☐	☐	_____	STD	☐	☐	_____	Other	☐	☐	_____
CONSTITUTIONAL				Other	☐	☐	_____	**NEUROLOGIC**			
Fatigue	☐	☐	_____	**HEMETOLOGY**				Headache	☐	☐	_____
Other	☐	☐	_____	Anemia	☐	☐	_____	Migraine	☐	☐	_____
ENT AND MOUTH				Sickle Cell	☐	☐	_____	Other	☐	☐	_____
Sinus Problems	☐	☐	_____	Other	☐	☐	_____	**PSYCHIATRIC**			
Other	☐	☐	_____	**IMMUNE**				Depression	☐	☐	_____
ENDOCRINE				HIV	☐	☐	_____	Other	☐	☐	_____
Diabetes	☐	☐	_____	Herpes	☐	☐	_____	**RESPIRATORY**			
Thyroid	☐	☐	_____	Sarcoidosis	☐	☐	_____	Asthma	☐	☐	_____
Other	☐	☐	_____	Lupus	☐	☐	_____	COPD	☐	☐	_____
				Arthritis-Rheumatoid	☐	☐	_____	Other	☐	☐	_____
				Other	☐	☐	_____				

Hobbies or Special Visual Needs: _____

Date of Last Eye Exam: _____

Surgeries: _____