



**Wyoming
Family
Vision Care**

"Come see the family difference!"

Welcome to our office. To enable us to meet your visual and eye health needs, please complete the following information:

Patient Information

Name:	Date of Birth:
Sex:	Account Responsible Name:
Address:	Home Phone:
	Cell Phone:
	Work Phone:

Visual Needs Assessment

Occupation: _____ Favorite leisure activities: _____

Employer: _____ Insurance Co: _____ Email: _____

How many hours do you spend per week: At a computer ____ Driving/Day ____ Driving/Night ____ Sports ____

Are you interested in: Glasses Contact Lenses Computer Lenses Safety Eyewear Sunglasses

Family Health History

Do your Parents, Grand-Parents, or Siblings have any of the following conditions:

Diabetes Blindness Heart Disease Tuberculosis Eye Disease

Patient Health History

Do you personally have any of the following conditions?

Asthma Diabetes Dental Problems Drug sensitivities Eye Disease Eye Surgery: _____
 Fainting Glaucoma Hay Fever Headaches Head Injury: _____
 High Blood Pressure Hypoglycemia Sinus Thyroid Macular Degeneration
 Skin Conditions: _____ Surgical Operations: _____
 Allergies: _____

Primary Care Physician: _____ PCP Phone number: _____

Date of last general health examination: _____ Any abnormalities from exam? _____

Are you currently taking any medications? Please list: _____

Payment Authorization

I authorize the doctors and staff of Wyoming Family Vision Care to perform services, and I authorize release of information relating to this claim. I authorize all third party payments directly to this provider for any benefits due (insurance related only). I understand that if insurance billing is approved, payment must be received from my insurance company within 30 days of the date of service or I am financially responsible and will pay my balance in full immediately. I understand Wyoming Family Vision Care will not become involved in divorce/custody agreements for any reason. The adult accompanying the minor will be responsible for any charges incurred. We will provide you with itemized statements to pass on to other responsible parties. We will not, however bill other parties directly. I understand that a written copy of this financial policy will be given to me upon request.

Patient Name **Signature (Must be over 18)** **Date**

HIPPA Privacy Policy

I acknowledge that I have received a copy of the Wyoming Family Vision Care Notice of Privacy Policies.

Patient Name **Signature (Must be over 18)** **Date**