# FAMILY VISION SOLUTIONS

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PATIENT NAME: _____ SEX: M / F SOCIAL SECURITY: _____-_____-_____

DATE OF BIRTH: _____/_____/_____ AGE: _____ EMPLOYER: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME # _____CELL# _____ WORK#_____

**Please select all that apply** □ **NO INSURANCE** □ **INSURANCE NOT LISTED BELOW**

**MEDICAL**

□ Blue Cross Blue Shield □ Aetna
□ Humana □ United Healthcare
□ Medicare Part B □ Cigna

**VISION**

□ VSP □ Cigna Vision
□ Eyemed □ Humana Vision
□ Superior

**INSURANCE CARD HOLDER: _____**

RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ OTHER

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY: _____-_____-_____ SEX: M / F

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME #_____CELL#_____WORK#_____

EMPLOYER: _____

**Children or Other Members on Card:**

NAME: _____DATE OF BIRTH: _____

NAME: _____DATE OF BIRTH: _____

**PHARMACY NAME: _____ PHONE #: _____**

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of any services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

**I have read and fully understand the above consent for treatment, financial responsibility, release of medical data and insurance authorization.**

Signature: _____ Date: _____

PHONE 713.349.0224 FAX 713.349.9834 5177 RICHMOND AVENUTE, SUITE 780 HOUSTON, TX 77056
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# Family Vision Solutions – New Patient Information Form

| | |
|---|---|
| **Today's Date** | **Name** |
| **Referred By** | _____ *May we send a thank you note?* __Yes __No |
| **Occupation** | |
| **Current Vision Correction** | □ Readers □ Soft Contact Lenses<br>□ Glasses □ Gas Permeable Contact Lenses<br>□ Sunglasses |
| **Special Vision Needs** | □ Sports □ Musician<br>□ Computer □ Other: _____ |
| **Health History:**<br>**Please Indicate**<br>**S=Self**<br>**F=Family** | □ __Blurred Vision □ __Hypertension □ __Kidney<br>□ __Glaucoma □ __Heart Disease □ __Nerves<br>□ __Cataracts □ __Diabetes □ __Asthma<br>□ __Dry Eyes □ __Cancer □ __Anemia<br>□ __Macular Degeneration □ __Arthritis □ __Other:<br>□ __Retinal Detachment □ __Lupus _____<br>□ __Strabismus □ __Thyroid |
| **Please List All Medications Currently Taken Including Over-the-Counter**<br>□ **LIST ATTACHED** | _____ _____ _____<br>_____ _____ _____<br>_____ _____ _____ |
| **Allergies to Medications**<br>□ **No Known Drug Allergies** | _____ _____ _____ |
| **Social History**<br>*This information is kept strictly confidential. You may discuss this directly with your doctor if you prefer.* | **Do you use tobacco products?** __Yes __No<br>*If yes:*<br>Type: _____<br>Amount: _____<br>How Long: _____<br><br>**Do you drink alcohol?** __Yes __No<br>*If yes:*<br>Type: _____<br>Amount: _____<br>How Long: _____ |
| **Emergency Contact**<br>□ **OK TO SHARE INFO** | _____ _____ _____<br>Name Relationship Phone Number |
| **Names of Other Person(s) With Whom We Can Share Your Health or Other Account Information** | *Please include anyone who might call to make/change appointments or order contacts:*<br>Name: _____ Relationship: _____<br>Name: _____ Relationship: _____ |
| **Preferred Phone Number**<br>□**Home** □**Work** □**Cell** | *Please initial to grant permission to leave voice messages on the phone number listed here:*<br>Phone: _____ Initials: _____ |
| **Text Messaging** | *Authorization for confirmation messages and other communications:* Initials: _____ |
| **Request for E-Mail Communication** | *I hereby acknowledge that e-mail between Family Vision Solutions and me is not encrypted and therefore not guaranteed to be private. I request Family Vision Solutions to accept and respond to e-mails from me, and grant permission for Family Vision Solutions to send newsletters, appointment confirmations, prescriptions and other requested Private Health Information via e-mail.*<br>***I will notify Family Vision Solutions of any changes to my E-Mail listed here:***<br>E-Mail: _____<br>Signature: _____ |

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