FAMILY EYE CARE
Dr. Melodie K. Wallace

Welcome to our office!
(Please Print)

Last Name_____ First Name_____ MI _____

Address_____

City_____ State_____ Zip_____

Telephone #_____ Secondary Telephone #_____

Occupation _____ Employer_____

Sex: M___ F___ Birth Date_____ Age_____ E-mail_____

Medical & Ocular History

Your reason for visiting our office today: _____

_____

Are you planning to get glasses today? _____

Are You planning to get contact lenses today? _____

ESTIMATED DATE OF LAST EYE EXAM :_____ PREVIOUS EYE DOCTOR:_____

PATIENT & RELATIVE HEALTH AND OCULAR HEALTH

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
Stroke	___	___	___	Cancer	___	___	___	Graves Disease	___	___	___
High Blood Pressure	___	___	___	Arthritis	___	___	___	AIDS (HIV+)	___	___	___
Hypothyroidism	___	___	___	Eye Surgery	___	___	___	Multiple Sclerosis	___	___	___
Heart disease	___	___	___	Asthma	___	___	___	Heart Disease	___	___	___
Diabetes	___	___	___	Cataracts	___	___	___	Macular Degeneration	___	___	___
Allergies	___	___	___	Glaucoma	___	___	___				

Please list **any** medications you are taking (prescription or over the counter) & the associated condition:

_____

_____

Are you interested in discussing Laser surgery options with the Doctor? _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP # _____

INSURED NAME _____

INSURED ID# _____ **INSURED** DATE OF BIRTH ___/___/___

INSURED RELATIONSHIP TO PATIENT: SELF ____ SPOUSE ____ CHILD ____

PATIENT NAME _____ **PATIENT** DATE OF BIRTH ___/___/___

PLEASE NOTE: By signing this document you do hereby agree to be financially responsible for any and all of the charges incurred by you, that are not paid by the Plan Sponsor. Payment is expected at the time services are rendered. Uncollected fees whether insurance, insufficient funds, check stop payment, credit card charge backs, etc. remain the responsibility of the patient (parent or legal guardian, if a minor).

SIGNED_____ DATE_____

THANK YOU FOR ALLOWING US TO SERVE YOU!