Wallis Family Eyecare

We require this form to be filled out every year. Thank you for your understanding.

Name: _____
(First) (Middle Initial) (Last)

Sex: M / F **Age:** _____ **DOB:** _____ **Cell phone:** _____

Home phone: _____ **Email:** _____

If the patient is under 18 years old, we need parent/guardian information:

Name: _____ DOB:_____

How did you hear about us? Who were you referred by? (circle one)
Insurance Panel / Yelp / Google / Work / Driving by / Doctor-Friend-Family **(Name)**: _____

Communication preference (circle one): Email / Telephone / Postal **Preferred language (circle one):** English / Spanish

Race (circle one): American Indian / Asian / African American / Hispanic / Caucasian / Other

Do you smoke tobacco? Yes / No **Do you drink alcohol?** Yes / No If yes, frequency _____

Eye issue(s): blurry distance / reading / computer _____

How many hours are you on the phone a day? _____ **How many hours are you on the computer a day?** _____

Do your eyes ever feel dry, burning, soreness or irritated? Yes / No If yes, frequency _____

Are you interested in contact lenses? Yes / No **Are you interested in LASIK/corrective surgery?** Yes / No

If there are no changes from our previous records, please put your **initials** in the boxes.

☐ Address: _____ City: _____ ST: ____ Zip:_____

SS#: _____ Drivers Lic#:_____ State: _____ Exp Date:_____

Occupation: _____ Hobbies:_____

If patient is NOT the insurance policyholder, please fill out below:

☐ Policy holder's name:_____ DOB:_____

☐ Policy holder's SS#: _____ Policy holder's relationship to patient: _____

I have read and understand the Patient Privacy Practices. Patient's or authorized person's signature, I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts the assignment. Insurer's or authorized person's signature, I authorize payment of medical benefits to the undersigned physician or supplier for the services described below.

Initials: _____ I understand that I will be charged a $25 No-Show/Cancellation fee if I do not call before the scheduled appointment time.

Initials: _____ I have read the "WALLIS FAMILY EYECARE COVID-19 GUIDELINES" and will follow them.

Signature (if under 18 years old, parent/guardian sign): _____Date:_____