Stacy L. Cantley, O. D.

FAMILY EYE CARE
Of Sylacauga, LLC

493 W Third Street
Sylacauga, AL 35150

Phone: 256-245-7696

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PLEASE COMPLETE ENTIRE FORM IN PRINT

Patient Information:

Patient Name: Last ________________________________ **First** __________________________________ **Middle** _________
Address: ____
City: _________________ State: _____ Zip: __________ Home#: ___________________Cell#: ___________________
Gender: M / F Birthdate: _______ /_______ /_______ SSN#: ________________ Ht: ________ Wt: __________
Employer: ____ Work #: ____
Emergency Contact: ______________________________ Phone: ____
Pharmacy: __________________________________ Previous Optometrist: ___________________________________
Email: ______________________________________ Physician: ____

PATIENT INFORMATION – *PARENT* must complete if patient is a *MINOR*

Mother's Name: ____________________________________
D.O.B: ______ /______ /______ SSN#: ________________
Address: ____
____
Phone: ______________________Work: _________________

Father's Name: _____________________________________
D.O.B: ______ / ______ / ______ SSN#: _______________
Address: ____
____
Phone: _____________________ Work: _________________

INSURANCE INFORMATION

(Primary) Insurance Company: ____ Policy Holder: _____________________
***Policy Holder's** D.O.B: _______ /_______ /_______ Employer: ____
Contract Number: _____________________________ Group Number: ____
(Secondary) Insurance Company: ______________________________________ Policy Holder: _____________________
***Policy Holder's** D.O.B: __________________________ Employer: ____
Contract Number: _____________________________ Group Number: ____

CONSENT FOR TREATMENT – I consent to necessary treatment including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the optometrist, his/her nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION – I authorize Family Eye Care of Sylacauga, LLC to furnish medical information requested by insurance companies with whom I have coverage, and public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to Family Eye Care of Sylacauga, LLC of benefits otherwise payable to me including major medical insurance and payment of surgical medical benefits, but not to exceed the Family Eye Care of Sylacauga, LLC charges for these services. I understand that I am financially responsible to Family Eye Care of Sylacauga, LLC for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination benefits.

GUARANTEE OF ACCOUNT – For services furnished by Family Eye Care of Sylacauga, LLC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

Signature: ____ **Date:** _____________________________________

CHIEF COMPLAINT / REASON FOR VISIT: ____
____

List **ALL** medications currently taking: ____
____
____

List **ALL** known allergies: ____

SOCIAL HISTORY

Occupation: _______________________________ / School/Grade: _____________________________________

Does your Occupation or hobby require special use of your eyes? YES / NO

EYE HISTORY

- Have **you** ever been diagnosed with or treated for – (Circle **ALL** that apply)

Headaches	Drooping Eyelid	Crossed Eyes	Floaters or Spots	Loss of side vision
Macular Degeneration	Color Blindness	Glare Light Sensitivity	Sandy/Gritty feeling	Blindness
Blurred Vision	Distorted Vision (halos)	Foreign Body Sensation	Detached Retina	Tired Eyes
Redness/Itching	Eye Surgery	Dryness	Burning	Loss of vision
Glaucoma	Diabetic Retinopathy	Amblyopia (lazy eye)	Eye pain or soreness	Cataracts
Double Vision	Fluctuating Vision	Blurred Near Vision	Mucous Discharge	Other

HEALTH HISTORY

- Have **you** ever been diagnosed with or treated for – (Circle **ALL** that apply)

Fever	Kidney	Allergy	Skin	Muscles, Bones, Joints
Ear, Nose, Throat	Respiratory	Psychiatric	Weight Loss	Neurological
Gastrointestinal	Blood/Lymph	Post-Nasal Drip	Chronic Cough	Kidney/Bladder
Kidneys	AIDS/HIV	Diabetes	Anemia	Joint pain
Stroke	Pregnant/Nursing	Thyroid Disease	Bleeding Problems	Lupus
High Blood Pressure	Rheumatoid Arthritis	Heart Disease	Consume Alcohol	Cancer
High Cholesterol	Emphysema	Smoking	Eye Surgery	Other

FAMILY HISTORY

- Has anyone in **your family** ever been diagnosed with or treated for – (Circle **ALL** that apply)

Arthritis	Cancer	Lupus	Macular Degeneration	Heart Disease
Stroke	Blindness	Detached Retina	Crossed Eyes	Kidney Disease
Amblyopia (lazy eye)	Thyroid Disease	Diabetes	Color Blindness	High Blood Pressure
Cataracts	Glaucoma	Eye Surgery	Other	