# Family Eye Care of O'Fallon, P.C.

852 Cambridge Blvd, #200

O'Fallon, IL 62269

(618) 628-2903

www.ofallonfec.com

Welcome to Family Eye Care of O'Fallon!

We look forward to providing you with personalized, professional service. To help your visit go more efficiently, please arrive 15 minutes early for your first appointment, and please bring the following items with you:

- ☐ Completed Patient Health History and Patient Registration forms (Below);
- ☐ Completed List of current medications and supplements – See below, or a more comprehensive form may be found here.
- ☐ Current Medical Insurance card and any Optical Insurance card you may have. It is important to inform us at the time of your visit of any Optical Insurance you would like to use. Optical Insurance cannot be directly applied after the visit or after glasses/contacts have been ordered.
- ☐ Current glasses and/or contacts, or the prescription for either. Empty contact lens boxes are also great to bring with you.

And please note that a parent or legal guardian must accompany all minors under the age of 18 for the first visit.

If you have any questions before then, please feel free to call us. If you cannot make your appointment for any reason, please let us know as soon as possible.

All of us at Family Eye Care of O'Fallon are excited to see you for your visit!

Thank you for trusting us with the health of your eyes,

The Doctors and Staff of Family Eye Care

# Welcome to Family Eye Care of O'Fallon
# Patient Registration Form

**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| **Status**<br>❑ Existing Patient ❑ New Patient | | | **Today's Date** |
| **Salutation**<br>❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Other | **Gender**<br>❑ Male ❑ Female | **Marital Status**<br>❑ Married ❑ Single ❑ Other | |
| **Full Name (First, Middle, Last)** | | | **Nickname** |
| **Home Address** | **City** | **State** | **Zip** |
| **Date of Birth** | **Social Security Number** | **Name of Parent or Guardian (If applicable)** | |
| **Preferred Language** | **Race**<br>❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American<br>❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other ❑ Unknown | | |
| **Ethnicity**<br>❑ Non-Hispanic or Latino ❑ Hispanic or Latino | **Dominant Eye**<br>❑ Right ❑ Left ❑ Unknown | | |
| **Employed Occupation / Student Grade Level** | **Employer / School** | **Position / Major** | |
| **Name of Primary Care Physician (PCP)** | **PCP City** | **PCP State** | **PCP Phone** |

**COMMUNICATION**

| **Home Phone**<br>( ) | **Work Phone**<br>( ) | **Cell Phone**<br>( ) | **Email** |
|---|---|---|---|

**How would you like for us to communicate with you?**

| | Home Phone | Work Phone | Cell Phone | Email | Mail |
|---|---|---|---|---|---|
| Appointment confirmation | ❑ | ❑ | ❑ | ❑ | |
| Recall for future appointment | | | | ❑ | ❑ |
| Order status | ❑ | ❑ | ❑ | ❑ | |
| Educational material | | | | ❑ | |

**REFERRAL**

| | | |
|---|---|---|
| **How did you hear about us?**<br>❑ N/A - I am an Existing Patient ❑ Doctor ❑ Family Member ❑ Friend ❑ Internet ❑ Advertisement | | |
| **Name of referring Doctor** | **Doctor work phone** | **Doctor work fax** |
| **Name of referring Family or Friend** | **May we contact them to say Thank you?**<br>❑ Yes ❑ No | |

**EMERGENCY**

**Who should we contact in case of an emergency?**

| **Name** | **Relationship** | **Home Phone**<br>( ) | **Cell Phone**<br>( ) |
|---|---|---|---|
| **Name** | **Relationship** | **Home Phone**<br>( ) | **Cell Phone**<br>( ) |

**Continue other side →**

## Insurance Information

**Do you have insurance?**

❑ Yes I have insurance coverage.

❑ No I do not have insurance coverage. Further, I understand that I am responsible for payment and services rendered to myself or my dependents at the time of service.

| | | | |
|---|---|---|---|
| **Vision** Insurance Company | | **Policy Holder Name** | |
| **Policy Holder Relationship to Patient** | **Policy Holder DOB** | **Policy Holder SSN** | **Policy Holder's Employer** |
| **Medical** Insurance Company | | **Policy Holder Name** | |
| **Policy Holder Relationship to Patient** | **Policy Holder DOB** | **Policy Holder SSN** | **Policy Holder's Employer** |
| **Member ID** | **Group #** | **Plan Name** | **Co-Pay** |

**Are there additional family members covered by this insurance?** ❑ Yes ❑ No

| Name | Relationship to Policy Holder | DOB | Coverage |
|---|---|---|---|
| | | | ❑ Vision/Optical ❑ Medical |
| | | | ❑ Vision/Optical ❑ Medical |
| | | | ❑ Vision/Optical ❑ Medical |
| | | | ❑ Vision/Optical ❑ Medical |
| | | | ❑ Vision/Optical ❑ Medical |

## Assignment of Benefits

**Insurance Authorization and Assignmen**t: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Dr. Vivian Kloke of Family Eye Care of O'Fallon, P.C. for any furnished services. I authorize Family Eye Care of O'Fallon, P.C. to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents which might provide coverage to me.

**All Services are the Responsibility of the Patient:** I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree that I am personally responsible for submitting the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due.

**Payments, Co-pays and Deductibles are Due at Time of Service:** I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials.

**Returned Checks:** I understand there is a **$25.00 fee** for any check returned by the bank. This fee will be added to the unpaid balance and both must be paid by cash or credit card.

**Collections:** I understand that if I fail to pay amounts owed, Family Eye Care of O'Fallon, P.C. has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

**With my signature, I confirm all of the above '*Patient Registration Form*' information is true and correct, and that I have read, understood and agree to the 'Assignment of Benefits' section.**

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

# Family Eye Care of O'Fallon
# Patient Health History

Name_____ Date_____

**HEALTH HISTORY**

**Do you take medications for, or have any of the following conditions?**

| **Constitution** | **Ear Nose and Throat** | **Neuro** | **Psychiatric** |
|---|---|---|---|
| ❑ **None** | ❑ **None** | ❑ **None** | ❑ **None** |
| ❑ Cancer | ❑ Dry mouth | ❑ Cerebral Palsy | ❑ Anxiety Disorder |
| ❑ Chronic Fatigue | ❑ Hearing Loss | ❑ Epilepsy | ❑ Attention Deficit |
| ❑ Developmental Disorder | ❑ Laryngitis | ❑ Migraine | ❑ Bipolar |
| ❑ Other: | ❑ Sinusitis | ❑ Multiple Sclerosis | ❑ Depression |
| | ❑ Other: | ❑ Stroke/CV | ❑ Other: |
| | | ❑ Tumor | |
| | | ❑ Other: | |
| **Cardiovascular** | **Respiratory** | **Gastrointestinal** | **Genitourinary** |
| ❑ **None** | ❑ **None** | ❑ **None** | ❑ **None** |
| ❑ Congestive Heart Failure | ❑ Asthma | ❑ Acid Reflux | ❑ Herpes |
| ❑ Heart Disease | ❑ Chronic Obstruction | ❑ Celiac disorder | ❑ Kidney Disease |
| ❑ Hypertension | ❑ Sleep Apnea | ❑ Colitis | ❑ Nursing |
| ❑ Vascular Disease | ❑ Emphysema | ❑ Crohn's Disease | ❑ Prostate ❑Disease/Cancer? |
| ❑ Stroke/CVA | ❑ Other: | ❑ Ulcer | ❑ STD: |
| ❑ Other: | | ❑ Other: | ❑ Other: |
| **Musculoskeletal** | **Integumentary (skin)** | **Endocrine** | **Hem/Lymph** |
| ❑ **None** | ❑ **None** | ❑ **None** | ❑ **None** |
| ❑ Ankylosing Spondylitis | ❑ Eczema | ❑ Hormonal dysfunctions | ❑ Ulcer |
| ❑ Arthritis | ❑ Herpes simplex/cold sores | | ❑ Anemia |
| ❑ Muscular dystrophy | ❑ Herpes zoster/shingles | ❑ Thyroid Dysfunction | ❑ High Cholesterol |
| ❑ Osteoarthritis | ❑ Psoriasis | ❑ Type I Diabetes | ❑ Other: |
| ❑ Osteoporosis | ❑ Rosacea | ❑ Type II Diabetes | |
| ❑ Other: | ❑ Other: | ❑ Other: | |
| **Allergy/immune** | **Additional Comments** | | |
| ❑ **None** | | | |
| ❑ Lupus | | | |
| ❑ Sjogren's Syndrome | | | |
| ❑ Rheumatoid Arthritis | | | |
| ❑ Other: | | | |

**MEDICATIONS**

| **Medication Name** | **Dosage** | **Prescribing Doctor** | **Reason** | **Start date** |
|---|---|---|---|---|
| ❑ **None** | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Continue other side →**

**ALLERGIES**

| Medication Allergies | Non-Medication Allergies (Animal, Plant, Food, Etc.) |
|---|---|
| ❑ **No known** | ❑ **No known** |
| | |
| | |
| | |

**OCULAR & SOCIAL HISTORY**

**Do you currently have, or had, any of the following?**

| | | | |
|---|---|---|---|
| ❑ **None** | ❑ **None** | ❑ **None** | ❑ **None** |
| ❑ Amblyopia | ❑ Glaucoma Suspect | ❑ Macular Degeneration | ❑ Retinal Detachment |
| ❑ Cataract | ❑ Inflammatory Disorder | ❑ Nystagmus | ❑ Retinal Hole |
| ❑ Dry eye | ❑ Injury | ❑ Patching | ❑ Strabismus |
| ❑ Glaucoma | ❑ Keratoconus | ❑ Retinal Degeneration | ❑ Surgery |
| ❑ LASIK / PRK | | | ❑ Other: |

**Smoking Status**

❑ Current everyday smoker (Smoked at least 100 cigarettes during lifetime and still smokes everyday)
❑ Current some day smoker (Smoked at least 100 cigarettes during lifetime and still smokes periodically yet consistently)
❑ Former smoker (Smoked at least 100 cigarettes during lifetime but does not currently smoke)
❑ Never smoker (Not smoked 100 or more cigarettes during lifetime)

**FAMILY HISTORY**

**Has anyone in your family had one or more of the following conditions?**

| | | | |
|---|---|---|---|
| ❑ **None** | ❑ **None** | ❑ **None** | ❑ **None** |
| ❑ Cancer | ❑ Amblyopia (Lazy Eye) | ❑ Glaucoma Suspect | ❑ Severe Myopia |
| ❑ Diabetes | ❑ Cataract | ❑ Macular Degeneration | ❑ Strabismus (Eye Turn) |
| ❑ Hypertension | ❑ Dry Eye | ❑ Nystagmus | ❑ Retinal Detachment |
| ❑ Thyroid | ❑ Glaucoma | ❑ Severe Hyperopia | ❑ Other: |
| ❑ Other: | | | |

**VISION WEAR**

**Eyeglass**

❑ Never Worn ❑ Distance Only ❑ Near Only ❑ Lined Bi/Trifocal ❑ Progressive (No-Line)

**Contact Lens**

❑ Never Worn ❑ Soft Lenses ❑ Gas Permeable Lenses ❑ Hard Lenses

| **Eye** | **Prescription (If known):** | **Brand:** |
|---|---|---|
| ❑ Right | | |
| ❑ Left | | |
| Average Daily Wearing Time: | Average Replacement Period: | Continuous Wear Period: |
| Solution Used: | Drops Used: | |

**Additional comments:**

**VISIT**

**Is there anything we may do to make your visit to Family Eye Care of O'Fallon more pleasurable?**

**With my signature, I confirm all of the above '*Patient Health History*' information is true and correct to the best of my knowledge.**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date