WELCOME TO MARCIANO FAMILY VISION

My information is the same as my last visit. ____YES (Continue to the back side and fill out medical history)		
PATIENT DEMOGRAPHIC INFORMATION		
Last, First, M:	Date of Birth:	
Street Address:	Apt #:	
City, State, Zip:		
Home Phone:	Cell Phone:	Email:
Patient Social Security Number:	Preferred Contact Method: Phone Text Email	
Male / Female	Marital Status: Married Single Divorced Widowed	
Employer:	Occupation:	Full time / Part Time
Preferred Language: English Spanish Other	Ethnicity: Hispanic/Latino Not Hispanic/Latino	
Race: Amer. Indian White Black/African American Hispanic Native Pac. Islander Asian		
Emergency Contact Name & Number:	Whom May We Thank for Your Referral?	
Medical Insurance ID Number Subscriber Name / DOB	Vision Insurance ID Number Subscriber Name / DOB	

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and received a copy of Marciano Family Vision's Notice of Privacy Practices as required by HIPAA regulations.

Name _____Signature:_____ Date:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with the fore mentioned insurance and assign directly to Marciano Family Vision all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or co-insurance. I also understand that if my insurance does not remit payment, I am responsible for any charges, whether paid or not paid by the insurance company. I, hereby, authorize the doctor to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

Signature: _____ Relationship to Party_____ Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ give my consent to Marciano Family Vision to release
(Print Patients Name)
medical conditions, test results, prescriptions, or medical records to the following individual(s). We will not honor disclosure of your medical information with anyone other than those stated without proper medical release forms on file.

1. _____ Relationship:_____

2. _____ Relationship:_____

Or _____ Do not release information to anyone but myself.

Patient Signature:_____Date:_____

EYE HISTORY

Date of Last Eye Exam:

Currently Wear Glasses:

Currently Wear Contacts: How Many Hours a Day:

Reason for Today's Visit:

Have you had any eye surgeries or systemic surgeries since your last visit?

Have you or a family member, experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

Cataracts	SELF	Family:
Cross Eye	SELF	Family:
Glaucoma	SELF	Family:
LASIK or RK/PRK	SELF	Family:
Lazy Eye	SELF	Family:
Macular Degeneration	SELF	Family:
Retinal Detachment	SELF	Family:

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

Blurry Vision	Near
Blurry Vision	Distance
Burning	
Discharge	
Double Vision	
Dryness	
Excess Tearing / Watering	
Eye Infection	
Eye Pain or Soreness	
Floaters or Spots	
Halos	
Headaches	
Itching	
Light Flashes	
Light Sensitivity	
Redness	
Sandy or Gritty Feeling	

MEDICAL HISTORY

Date of Last Physical Exam:

Primary Care Doctors Name:

Primary Care Doctors Number:

Pharmacy:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

AIDS / HIV	SELF	Family:
Allergies	SELF	Family:
Arthritis	SELF	Family:
Asthma	SELF	Family:
Blood / Lymph Disorder	SELF	Family:
Cancer	SELF	Family:
Diabetes	SELF	Family:
Ears, Nose, Throat Conditions	SELF	Family:
Gastrointestinal Conditions	SELF	Family:
Heart Disease	SELF	Family:
High Blood Pressure	SELF	Family:
High Cholesterol	SELF	Family:
Kidney Disease	SELF	Family:
Lupus	SELF	Family:
Neurological Conditions	SELF	Family:
Psychiatric Disorder	SELF	Family:
Seizures	SELF	Family:
Skin Conditions	SELF	Family:
Stroke	SELF	Family:
Thyroid Dysfunction	SELF	Family:

Current Medications:

Are you allergic to any medications?

Hobbies:	Sports:
Are you Pregnant or Nursing? :	
Do You Smoke?	How Often:
Do You Drink?	How Often:
Height:	Weight:

Marciano Family Vision Wellness Form

Name _____ Temp _____

Do you have a cough?

Yes ○ No ○

Do you have a fever now or have you in the past 14-21 days?

Yes ○ No ○

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

Yes ○ No ○

Are you experiencing shortness of breath or difficulty breathing?

Yes ○ No ○

Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes ○ No ○

Have you experienced recent loss of taste or smell?

Yes ○ No ○

Have you taken a COV-19 test and have not received the results at this time?

Yes ○ No ○

Have you tested positive for COV-19 and have yet to re-test for a negative result?

Yes ○ No ○

Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

Yes ○ No ○

Signature _____ Date _____

(Signature and date only valid within 24 hours of appointment)

RETURN POLICY

No refund will be made on professional services or procedures, including comprehensive eye examinations, refractions, contact lens examinations, and medical office visits. Also, there are no refunds on customized prescription eyeglasses, including frames and lenses. All lenses are customized for you and can be remade if there is a doctor prescription change, but no refund will be given. Any unopened boxes of contact lenses can be exchanged if your prescription changes, within a year of the purchase.

Name (Print)_____Signature:_____Date:_____