# WELCOME TO MARCIANO FAMILY

**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 Carrier: | | Vision Insurance Carrier: |

**NOTICE OF PRIVACY PRACTICES**

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

Print 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 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 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:_____

**RETURN POLICY:** No refunds will be made on professional services or procedures; including comprehensive eye exams, refractions, contact lens fitting fees and medical office visits. There are **NO REFUNDS** on customized prescription glasses, including frames and lenses. **All lenses are customized for you and cannot be returned.** If there is a doctor's prescription change, within 60 days of purchase, lenses will be re-made at no cost to you. Any unopened/undamaged/unwritten on boxes of contact lenses can be exchanged within 60 days of purchase if your prescription changes. Any exceptions to these policies may incur a restocking fee of 10% of U&C and must be approved by management.

Patient/Guardian 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: |

Other:

**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 (Including Ocular 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: |