Name: _____

❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr.

Address: _____

_____

City _____ State _____ Zip _____

Ph:_____ (H) _____ (W) _____ (C)

May we text you appointment reminders? ❒ Y ❒ N

Email:_____

DOB: _____/_____/_____ SS#_____

Employer: _____ Occupation: _____

Emergency Contact (Name and Phone Number):

_____ Ph. _____

Marital Status: ❒ Single ❒ Married ❒ Other _____

Primary Insurance Holder: _____

Relationship to Primary Insurance Holder: _____

Primary Ins. DOB: _____

How did you hear about us?

❒ Yellowpages ❒ Insurance ❒ Internet ❒ Employer

❒ Patient referral _____ (name)

❒ Doctor referral _____ (name)

❒ Other? _____

Medical Insurance?		*Vision Insurance?*	
❒ BCBS	❒ Medicare	❒ VSP	❒ CommEye
❒ UHC	❒ Medicaid	❒ Superior	❒ EyeMed
❒ Medcost	❒ Humana	❒ Other?	

Financial Arrangements

We will file your insurance. Please read the following below: I understand, request that payment of authorized insurance benefits be made payable to me or on my behalf to Dr. James Fanelli/Dr. Jamie Casper (Fanelli Eye Associates, O.D., P.A.) for any services furnished/rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. We file insurance as a courtesy to our patients. All co-payments and non-covered services are your responsibility and are due upon checkout or notification by your insurance company of fees due to Fanelli Eye Associates, O.D., P.A.

If my insurance does not pay, I am responsible for services rendered and products sold. If your deductible has not been met, full payment is due at time of service.

Signature: _____ Date: _____

Payment policy requires all fees paid at the time of visit.

Payment method: ❒ Cash ❒ Check ❒ Credit/Debit

Welcome to the Cape Fear Eye Institute OD PA

An ophthalmic medical and vision practice with an optical boutique

Dr. James L. Fanelli
Dr. Jamie J. Casper

To better serve your vision needs, please answer the following:

Do you wear glasses? ❒ Yes ❒ No

if yes: ❒ All the time ❒ Distance only ❒ Occasionally ❒ Reading only

Are you bothered by glare at night? ❒ Yes ❒ No

How much time do you spend on the computer?

❒ None ❒ 1-2 hrs ❒ 3-6 hrs ❒ More

How much time do you spend in the sun weekly?

❒ None ❒ 1-5 hrs ❒ 6-12 hrs ❒ More

Are you interested in purchasing eyewear today?

❒ Yes ❒ No

What hobbies or rec. activities do you enjoy?

❒ Golf ❒ Fishing ❒ Biking ❒ Hunting

❒ Video games ❒ Watching TV ❒ Reading

❒ Sports? _____ ❒ Other? _____

Do you wear contacts? ❒ Yes ❒ No

If no, are you interested in contacts? ❒ Yes ❒ No

Do you sleep in your contacts? ❒ Yes ❒ No

Are you interested in refractive surgery? ❒ Yes ❒ No

Are you interested in purchasing contact lenses today?

❒ Yes ❒ No

Describe any problems you have with your contacts:

Eye Health History

	Yes	No		Yes	No
Blur Distance	❒	❒	Macular Degeneration	❒	❒
Blur Near	❒	❒			
Cataract	❒	❒	Redness	❒	❒
Double Vision	❒	❒	Eye Pain	❒	❒
Dry Eye	❒	❒	Light sensitivity	❒	❒
Eye Allergies	❒	❒	LASIK	❒	❒
Eye Strain	❒	❒	Trauma	❒	❒
Itch	❒	❒	Vision Loss	❒	❒
Water	❒	❒	Iritis	❒	❒
Flashes	❒	❒	Migraine Headache	❒	❒
Floaters	❒	❒			
Glaucoma	❒	❒	Crossed Eyes	❒	❒

Primary Care Physician Name _____ Date of last visit: _____

Please indicate if you have, or ever had any of the following by checking box(es)

Cardiovascular	*Gastrointestinal*	*Hematologic/Lymphatic*	*Musculoskeletal*
❒ Congestive Heart Failure	❒ Acid reflux/GERD	❒ Anemia	❒ Arthritis
❒ High Blood Pressure	❒ Liver disease	❒ Breast cancer	❒ Osteoporosis
❒ Angina/Arrhythmia	❒ Ulcers	❒ Leukemia	❒ Joint pain
❒ Myocardial Infarction/Attack	❒ Other:	❒ Clotting problems	❒ Other:
❒ Bypass surgery/Stints		❒ Other:	
❒ Other:			

Endocrine	*Genitourinary*	*Immunologic*	*Nervous*
❒ High cholesterol	❒ Bladder Problems	❒ HIV/AIDS	❒ Myasthenia Gravis
❒ Diabetes* (if yes, see below)	❒ Kidney Stones	❒ Gonorrhea/Chlamydia	❒ Multiple Sclerosis
❒ Thyroid disease	❒ Prostate /Ovarian	❒ Hepatitis/Syphilis/TB	❒ Stroke / Siezures
❒ Other:	❒ Other:	❒ Other:	❒ Other:

*Diabetes**	*Head*	*Skin*	*Psychiatric*
How long diabetic? _____ years	❒ Sinusitis	❒ Rosacea	❒ Alzheimer's
Insulin dependent? ❒ Y ❒ N	❒ Headaches	❒ Dry Skin	❒ Depression
Last Blood Sugar? _____	❒ Hearing loss	❒ Psoriasis/Eczema	❒ Bipolar/Schizophrenic
Last HbA1C? _____ (range 4-14)	❒ Other:	❒ Other:	❒ Other:

Social History

Current Tobacco use? ❒ Y ❒ N
Daily smoker? ❒ Y ❒ N
Former smoker? ❒ Y ❒ N
Alcohol use? ❒ Y ❒ N ❒ Social
Rec. drugs? ❒ Y ❒ N
Pregnant? ❒ Y ❒ N

Weight? _____lbs approx.
Height? _____ft _____in approx.

Family Health History

	Yes	No	Who?
Cataracts	❒	❒	
Glaucoma	❒	❒	
Mac. Degen.	❒	❒	
Diabetes	❒	❒	
Heart disease	❒	❒	
High BP	❒	❒	
Arthritis	❒	❒	
Stroke	❒	❒	

Eye Medications

❒ None
❒ Artificial tears
How often? _____
❒ Other?

Medications:

Respiratory

❒ Asthma
❒ Bronchitis
❒ COPD
❒ Other:

Medication Allergies:

Thank you for trusting us with you and your family's eye care.
If you have an eye emergency in the future, call our office.
Please visit: www.capefeareyeinstitute.com