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?

❒ BCBS ❒ Medicare

❒ UHC ❒ Medicaid

❒ Medcost ❒ Humana

Vision Insurance?

❒ VSP ❒ CommEye

❒ Superior ❒ EyeMed

❒ 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
- ❒ Congestive Heart Failure
- ❒ High Blood Pressure
- ❒ Angina/Arrhythmia
- ❒ Myocardial Infarction/Attack
- ❒ Bypass surgery/Stints
- ❒ Other:

Gastrointestinal
- ❒ Acid reflux/GERD
- ❒ Liver disease
- ❒ Ulcers
- ❒ Other:

Hematologic/Lymphatic
- ❒ Anemia
- ❒ Breast cancer
- ❒ Leukemia
- ❒ Clotting problems
- ❒ Other:

Musculoskeletal
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Joint pain
- ❒ Other:

Endocrine
- ❒ High cholesterol
- ❒ Diabetes* (if yes, see below)
- ❒ Thyroid disease
- ❒ Other:

Genitourinary
- ❒ Bladder Problems
- ❒ Kidney Stones
- ❒ Prostate /Ovarian
- ❒ Other:

Immunologic
- ❒ HIV/AIDS
- ❒ Gonorrhea/Chlamydia
- ❒ Hepatitis/Syphilis/TB
- ❒ Other:

Nervous
- ❒ Myasthenia Gravis
- ❒ Multiple Sclerosis
- ❒ Stroke / Siezures
- ❒ Other:

*Diabetes**

How long diabetic? ______ years

Insulin dependent? ❒ Y ❒ N

Last Blood Sugar? ______

Last HbA1C? ______ (range 4-14)

Head
- ❒ Sinusitis
- ❒ Headaches
- ❒ Hearing loss
- ❒ Other:

Skin
- ❒ Rosacea
- ❒ Dry Skin
- ❒ Psoriasis/Eczema
- ❒ Other:

Psychiatric
- ❒ Alzheimer's
- ❒ Depression
- ❒ Bipolar/Schizophrenic
- ❒ 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?

Respiratory
- ❒ Asthma
- ❒ Bronchitis
- ❒ COPD
- ❒ Other:

Medications:

Medication Allergies:

ROS/PFSH

Date __________ by _____

Date __________ by _____

Date __________ by _____

Date __________ by

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