FAMILY EYECARE &
CONTACT LENS CENTER, LLC

Dr. Kristie Chevalier, O.D.
Dr. Austin Krohn, O.D
3325 Maine Street
Quincy, Illinois 62301
(217) 231-3937

Welcome to Our Office

Today's Date___________________

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name________________________________ First Name _____________________________MI__________
Address__________________________________ Emergency Contact Name______________________________
City, State, Zip___________________________ Phone (________)_________________________________
Work Phone (________)____________________ Date of Last Eye Exam_____________________________
Home Phone (________)____________________ Dilated? ☐Yes ☐No
Email Address ____________________________ Referred By______________________________________
Date of Birth______________________________ Primary Vision Coverage___________________________
Occupation_______________________________ Social Security Number____________________________
Employer_________________________________

MEDICAL INFORMATION

How is your general health?____

Do you take medications for any of these systems? (Please check Yes or No boxes.)

Gastrointestinal	☐Yes ☐No	Nervous	☐Yes ☐No	Endocrine	☐Yes ☐No
Ears/Nose Throat	☐Yes ☐No	Urinary	☐Yes ☐No	Blood/Lymph	☐Yes ☐No
Cardiovascular	☐Yes ☐No	Muscles/Bones	☐Yes ☐No	Allergic/Immu	☐Yes ☐No
Respiratory	☐Yes ☐No	Integumentary(skin)	☐Yes ☐No	Headaches	☐Yes ☐No
High blood pressure	☐Yes ☐No	Eyes	☐Yes ☐No	Mental	☐Yes ☐No

Please explain____
Diabetes ☐Yes ☐No_________________________Type__________Date of diagnosis_______________________
Allergies to medication ☐Yes ☐No Which?____________________Reactions?______________________________
Other health problems____
Current medications____
Have you had any operations? ☐Yes ☐No No Kind?_________________________When?_____________________
Name of family doctor and/or primary care physician______________________________________
Date of last visit?___________________________Date your blood pressure was last checked?_________________

FAMILY HISTORY

High blood pressure	☐Yes ☐No	Relation______	Macular degeneration	☐Yes ☐No	Relation ___
Diabetes	☐Yes ☐No	Relation______	Retinal detachment	☐Yes ☐No	Relation___
Glaucoma	☐Yes ☐No	Relation______	Cataracts	☐Yes ☐No	Relation___

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ☐Yes ☐No What Kind?_____________________________
Have you had any eye operations? ☐Yes ☐No Type?______________________________Date_______________
Have you had any eye injury?☐Yes ☐No Kind?____________________________________Date_______________

Do you have glaucoma?	☐Yes ☐No	Cataracts?	☐Yes ☐No	Dry eyes?	☐Yes ☐No
Macular degeneration?	☐Yes ☐No	Retinal detachment?	☐Yes ☐No	Blurred vision?	☐Yes ☐No
Do you wear glasses?	☐Yes ☐No	Contact Lenses?	☐Yes ☐No	Type___________________	

Additional Information: ____

How did you hear about our office?

☐ Friend or relative. Who? ________________________ ☐ Radio advertisement. Which station?_____________
☐ Previous patient. Who? _________________________ ☐ Another health care practitioner. Who? __________
☐ Participating eye care plan. _____________________ ☐ Other_______________________________________

CONSENT FOR TREATMENT

Dr. Chevalier and Dr. Krohn are here by authorized to render services, medication and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Chevalier and Dr. Krohn are participating Medicare providers.

INSURANCE RELEASE

I authorize the release of medical information containing my medical records to family physicians and or insurance companies. A photocopy of this authorization shall be as valid as the original. I assume responsibility for any balance above insurance.

LATE / NO SHOW POLICY

It is in the policy of Family Eyecare & Contact Lens Center, LLC that if a patient misses more than three (3) appointments in 1 year without calling to cancel, they will be made walk-in only. A patient is considered "LATE" if they are more than 15 minutes late for their scheduled appointment. It is at the discretion of the provider as to whether the patient can still be seen as they will need to reschedule.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME SERVICES ARE RENDERED. ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS. ANY ACCOUNT WITH A BALANCE OVER 90 DAYS WILL BE SENT TO COLLECTIONS UNLESS ARRANGEMENTS HAVE BEEN MADE.

Signature: ____

Date: ___________________________