Vision Source
The Family Eye Site

Dr. Caleb Kennedy • Optometric Physician

Today's Date ______________________

Patient Information

Last ______________________
First ______________________ MI __________
Address ______________________
City ______________________ State ______
Zip Code ______________________
Home Phone ______________________
Cell Phone ______________________
Work ______________________
Patient's SSN ______________________
Employer (or School) ______________________
Occupation (or Grade) ______________________
Spouse (or Parent's) Name ______________________
DOB: Mo__________ Day__________ Yr__________
Sex M F
E-mail____________________@____________
What is the major purpose of this visit?
____
____

Any problems with your current contact lenses or glasses?
____
____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative ______________________
If not referred, how did you choose our office?
__ Another Dr.
__ Our City Magazine
__ Insurance List
__ Saw Sign/Building
__ Newspaper/Radio/TV
__ Yellow Pages: Which directory? ______________
__ Web Page: Which Website? ______________
__ Other ______________________

At the Family Eye Site, we are committed to treat our patients as we would our family and friends...with respect and a caring attitude. We are devoted to our profession by providing the highest level of quality eye care to each patient. We are dedicated to raise the awareness of the importance of vision and how it affects their lives and future.

Insurance Information

Vision Insurance ______________________
Subscriber Name ______________________
Subscriber SSN ______________________
Subscriber Birth Date / /

Primary Medical Insurance ______________________
Subscriber Name ______________________
Subscriber SSN ______________________
Subscriber Birth Date / /

Do you participate in a flex spending account?
__ YES __ NO
How will you settle your account today?
__ Cash __ Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)
__ work at a computer?
__ think you might benefit from thinner, lighter lenses?
__ what are your hobbies? ______________________
__ what is your occupation? ______________________
__ get bother by glare from on-coming headlights while driving at night?
__ prefer not to wear your glasses at times?
__ want information on Laser Vision Correction surgery?
__ have interest in a non-surgical approach to vision correction?
__ have more than 1 pair of current Rx eyewear?
__ have children?
__ have family members in need off eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

__ Blurry Vision
__ Burning
__ Cataracts
__ Corneal Abrasions
__ Crossed eye
__ Double Vision
__ Eye Infections
__ Eye Injury
__ Flash of Lights
__ Floaters/Spots
__ Glaucoma
__ Grittiness
__ Headaches
__ Iritis/Uveitis
__ Itchiness
__ Lazy Eye
__ Macular Degeneration
__ Occasional dryness
__ Retinal Detachment
__ Sunlight Sensitivity
__ Tearing
__ Trouble seeing at night
__ Uncomfortable glasses
__ Other eye disorders______________________

The information in this confidential case history form is critical to the evaluation of your vision and health

Patient Medical History	**Patient Eye History**
Name of Family Physician ________________	Date of Last Eye Exam / /
City ______________________________	By Whom? ______________________
Date of Last Physical Check-Up / /	Have you ever tried contact lenses? __ Yes __ No
	Do you wear contact lenses? __ Yes __ No
CURRENT MEDICATIONS (Rx or over the Counter) ______________________	What kind? ______________________
______________________________	Solutions used ______________________
	Are you satisfied with the vision and comfort of your contact lenses? __ Yes ___ No
Allergies to medications? __ Yes __ No	Would you prefer clear contact lenses or colored contact lenses? __ Yes __ No
If so, what medications? ______________________________ ______________________________	If you wear bifocals, do the lines or head tilting bother you? __ Yes __ No
Do you use: Cigarettes or tobacco? __ Yes __ No	
Alcohol? __ Yes __ No	**Family Medical/Eye History (Check all that apply)**
Other substances? __ Yes __ No	
Have you ever been diagnosed or treated for the following health problems?	Is there a family medical history of any following: (Mother's or Father's side)
__ Allergies __ Throat Infections	High Blood Pressure ▫ ________________
__ Blood/Lymph __ Weight loss/gain	Diabetes ▫ ________________
__ Cancer __ Arthritis	Blindness ▫ ________________
__ Diabetes __ Bronchitis	Cataracts ▫ ________________
__ Ears/Nose/Throat __ Cholesterol	Glaucoma ▫ ________________
__ Eczema/Rashes __ Digestive	Corneal Problems ▫ ________________
__ Fevers __ Endocrine	Heart Disease ▫ ________________
__ High Blood Pressure __ Genitourinary	Lazy Eye ▫ ________________
__ Kidney __ Thyroid	Macular Degeneration ▫ ________________
__ Neurological __ Muscle/Bone	Retinal Problems ▫ ________________
__ Respiratory __ Sinus	

I authorize Dr. Caleb J. Kennedy to release any information including the diagnosis, examination and treatment records for me during the period of care to my third-party payer or insurance company. I understand insurance may only cover part of my incurred charges. If my insurance is not accepted, I agree to pay Dr. Caleb J. Kennedy and will be responsible for filing my own insurance claim. If my insurance does not pay as expected, I am ultimately responsible for all my charges. I understand that The Family Eye Site may contact me letting me know when contacts, glasses, supplies are ready and this may include communication by e-mail, text messages, and/or newsletters.

Signature ______________________________

Relationship (if patient is a minor)

Dr. Caleb Kennedy • Optometric Physician
18503 Pines Blvd. • Suite 205 • Pembroke Pines, FL 33029
Telephone: 954•430•8330 Fax: 954•430•3638
www.FamilyEyeSite.com Email: DrKennedy@FamilyEyeSite.com

Receipt of Notice of Privacy practices
Written Acknowledgement

I, ____________________, have reviewed/received a copy of **Caleb Kennedy, O. D's** Notice of privacy
Patient Name
Practices.

Signature ____ Date ______________________

Relationship if patient is minor___________________________

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices

Acknowledgement, but was unable to do so as documented below:

Date________________ Initials_____________ Reason: ___________________________________

Consent to Share Medical Information

I give permission to share medical information with the person(s) named below:

Name ____

Name ____

Primary Care Physician ____

I may revoke this permission at any time when provided in writing to this office.

____________________________ ____________________

Print Patient Name Date

____

Signature

Relationship if patient is a minor ____

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Office Financial Policy

Thank you for choosing Vision Source-The Family Eye Site, the office of Dr. Caleb Kennedy. Our goal is to deliver the best and most comprehensive vision care available. An important part of that goal is to make the cost of optimal care as easy and manageable as possible for our patient by offering several payment options.

Payment Options:

You can choose from:

- **Cash, Visa, Mastercard, American Express or Discover.**
- **No Interest*Payment Plans**from Care Credit**
  - **Allow you to pay for 6 months with no interest**
  - **Convenient, low monthly payment plan**available**
  - **No annual fees of prepay-payment penalties.**

Payment Policies:

Payment is required at the time of your examination.

Materials ordered (contacts lenses, prescription and non-prescription eyewear) require a minimum 50% payment to process order. Payment in full is gladly accepted. Materials ordered with a 50% deposit is required to be picked-up and paid in full within 30 days of notification from our office that the item is ready. Orders not picked up after 30-day notification, are subject to cancelation without refund of deposit.

All co-payments for insurance covered services are to be paid at the time of service.

For patients with vision insurance we are happy to work with your plan to maximize your benefits and directly bill them for the services and/or products that you ordered.

However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment for those services and products billed and collection of your benefits directly from your insurance carrier. Services billed to insurance and not covered by your plan will be billed to you. Payment required upon receipt of statement.

Eyeglasses ordered through vision plans are processed electronically within a few hours, once ordered with the insurance laboratory, we are unable to cancel. Should you need to cancel after the order has been placed, there is a 50% cancelation charge.

If you have any questions, please do not hesitate to ask. We are here to help you.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please print)

*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

**Subject to credit approval