

**ADVANCED FAMILY EYE CARE**

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**Welcome To Our Office**

Today's Date \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M \_\_\_ F \_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Employer (or School) \_\_\_\_\_  
Occupation \_\_\_\_\_

Spouse (or Parent's) Name \_\_\_\_\_  
Spouse (or Parent's) Work \_\_\_\_\_

E-mail address \_\_\_\_\_  
Can we contact you? Y N

**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 for your needs?

- Another Dr. \_\_\_\_\_ Insurance List \_\_\_\_\_
- Saw Sign/Building \_\_\_\_\_ Newspaper/Radio/TV \_\_\_\_\_
- Yellow Pages. Which directory? \_\_\_\_\_
- Web Page. Which web site? \_\_\_\_\_
- Other \_\_\_\_\_

**Insurance Information**

**Vision Insurance:** \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber Social Security Number: \_\_\_\_\_  
Subscriber Birth Date: \_\_\_\_\_

**Primary Medical Insurance:** \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber ID Number (include letters): \_\_\_\_\_  
Subscriber Birth Date: \_\_\_\_\_

Do you participate in a flex spending account? Yes No

How will you settle your account today?  
Check Cash Credit Card

**Family Medical/Eye History (Check all that apply)**

Is there a family medical history of any of the following?

	Relationship
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____
Diabetes	_____
Heart Disease	_____

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

**Patient Medical History**

**CURRENT MEDICATIONS (Rx or Over-the-Counter)**

(List name of medications including eye drops, vitamins and birth control pills) \_\_\_\_\_

Allergies to Medications: Yes No

Females: Are you pregnant/nursing? Yes No

**Patient Eye History**

Date of Last Exam \_\_\_\_\_  
By Whom? \_\_\_\_\_

Do you currently wear contact lenses? Yes No  
What kind? \_\_\_\_\_

Have you ever tried contact lenses? Yes No

Would you prefer clear contact lenses or colored contact lenses to change the color of your eyes? \_\_\_\_\_

**Do you.....(Check if your answer is yes)**

- \_\_\_ Work at a computer?
- \_\_\_ Sometimes experience dry eyes?
- \_\_\_ Think you might benefit from thinner, lighter lenses?
- \_\_\_ Have an interest in a "Test Drive" of the latest contact lens design?
- \_\_\_ Spend time outdoors? (How much?) \_\_\_\_\_ hrs/week
- \_\_\_ Have prescription sunglasses?
- \_\_\_ Prefer not to wear your glasses at times?
- \_\_\_ Want information on Laser Vision Correction?
- \_\_\_ Have more than 1 pair of current Rx glasses?
- \_\_\_ Have children?
- \_\_\_ Have family members in need of eye care?