fab
EYE CARE CENTER

286 Griffen Street
Phoenixville, PA 1946
P:(610) 933-1144
F:(610) 933-7067

270 Lancaster Ave., Suite F-1
Malvern, Pa 19355
P:(610) 647-6550
F:(610) 647-6549

Barry Fabriziani, OD, FAAO
Jonathon Fabriziani, OD
Joshua Fabriziani, OD
Charles Griffen, OD, FAAO
Sara Bierwerth, OD FAAO
James Lewis, MD

WELCOME TO OUR PRACTICE
New Patient Registration

Date: _____

Patient Information:

First Name: _____ MI: ___ Last Name: _____

Date of Birth: _____, Social Security#: _____
(We use this for billing/insurance purposes and a 3rd way to identify patients if needed.)

Gender: _____ Occupation: _____ Marital Status: _____

Guardian (if applicable): _____ Guardian Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

Name of Primary Doctor: _____ Location: _____

Name of Pharmacy: _____ Location: _____

How did you hear about our practice?: _____

Insurance:

Who is responsible for this account?: _____

Relationship to patient: _____ Date of Birth: _____

Do you have Vision Benefits? _____ Name of Vision: _____

If VSP, last 4 digits of SSN for the policy holder or their unique ID: _____

Name of Primary Medical Insurance: _____

ID#: _____ Group#: _____

Name of Secondary Insurance (if applicable): _____

ID#: _____ Group#: _____

Financial Assignment and Release of Information:

I certify that I, or my dependant(s), have insurance coverage as listed above and assign directly to Fab Eye Care Center all insurance benefit, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not paid by insurance, unless prior arrangements have been made. I authorize the use of my signature on all insurance submissions.

Signature of patient, parent or guardian: _____

Patient General Health History:

Primary Care Physician: _____ Location: _____

Please list any allergies to:

Medications: _____

_____

Seasonal: _____

_____

Please list any current medications (including eye drops and over the counter supplements and vitamins):

_____

_____

_____

Are you pregnant or nursing: _____

Do you have or have had any of the following (please check those that apply)?:

___ Diabetes (if so, which type?: _____)
___ High Blood Pressure
___ Heart Disease
___ Poor Circulation
___ Cancer
___ Kidney Disease
___ Arthritis
___ Seizures
___ Lung Disease
___ Stroke
___ GI Disease
___ Thyroid Condition
___ Asthma
___ Headaches/Migraines
___ Shingles
___ Skin Condition

Other Conditions Not Listed Above: _____

_____

_____

Eye Health History:

Do you wear Glasses?:_____ Do you wear Contact Lenses?: _____

If you do wear contact lenses, what type of contacts do you wear?: _____

How often do you change them?:_____

Any past ocular history/ocular surgery?: _____ Explain: _____

_____

_____

Have you ever been diagnosed with or experienced any of the following (please check all that apply)?:

___ Cataracts	___ Itchy Eyes
___ Glaucoma	___ Loss of Vision
___ Double Vision	___ Poor Color Vision
___ Dry Eyes	___ Retinal Detachment
___ Eye Injury	___ Crossed Eyes
___ Flashes	___ Lazy Eye
___ Floaters or Spots	___ Other: _____
___ Macular Degeneration	_____

Social History:

Do you drive?: _____

Do you use tobacco products?: _____ If yes, type/amount:_____

_____

Do you drink alcohol?: _____ If yes, type/amount/how long: _____

_____

Do you use illegal drugs?: _____ If yes, type/amount/how long: _____

Family Medical History:

Relationship to You:

___ Cancer _____

___ Diabetes _____

___ Heart Disease _____

___ High Blood Pressure _____

___ Kidney Disease _____

___ Lung Disease _____

___ Thyroid Disease _____

Other conditions not listed above: _____

Family Eye History:

Relationship to You:

___ Cataracts _____

___ Glaucoma _____

___ Macular Degeneration _____

___ Blindness _____

Other Conditions Not Listed Above: _____

_____

Effective September 24, 2024

In the efforts of complying with the FTC rule, we will provide you with your Rx after your routine appointment.

Patient's Signature: _____

Date: _____

Guardian if under 18: _____

Date: _____