GAILMARD EYE CENTER

Date_____

Patient's name (minor, age 18 or younger)_____

Parents' names_____

Address_____City_____ State____Zip_____

Home Phone_____ Work Phone_____

Parent's Cell Phone_____Parent's Email_____
Texting ok? ❑ Email ok? ❑

Who referred you to our office? (Name)_____
❑Insurance listing ❑Family member ❑Yellow pages ❑Physician/Eye Doctor ❑ Think About Your Eyes

Patient's date of birth_____ Grade in school _____

Name of parent responsible for account_____

Parent's Occupation_____Parent's Social Security Number_____-____-_____

Name of employer_____City_____

Do any members of your household come to our office?_____

Please list any eye problems, medical problems or learning/developmental problems the patient has:

_____

Who is the patient's family physician?_____

Have any blood line relatives had glaucoma, or other loss of sight?_____

Is patient allergic to any medications? ❑Yes ❑ No (List)_____

Does patient presently wear glasses? ❑Yes ❑No How old are the glasses?_____

When does he/she wear them? _____

Does patient presently wear contact lenses? ❑Yes ❑No ❑Hard Gas ❑Permeable ❑Soft Disposable

If yes, how old are the contacts?_____ If no, has patient ever worn contacts? ❑Yes ❑No

Previous eye doctor_____

Does patient have vision care insurance? ❑Yes ❑No Name and ID#_____

Do you have health insurance? ❑Yes ❑No Name and ID#_____

Please note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist.