NEW PATIENT FORM GERARD EYE CO.

Name_____ Date of Birth_____

Spouse/Parent_____ Age___Male__ Female__Eye Color____

Address_____ Phone Number_____

_____ Work Number_____

Occupation_____ Cell Number _____

Social Security Number_____-___-_____ E-mail _____

Vision Insurance_____ Medical Insurance_____

Medical Physician_____

PAST OCULAR HISTORY

Date of Last Eye Exam_____ Date of Last Pair of Glasses_____
History of Eye Trauma_____
History of Eye Surgery_____

Eye Diseases (Glaucoma, Cataracts, Retinal Detachment, Macular Degeneration)
Please list any that apply:

Do you have dry eyes? Yes/No Blurred vision? Yes/No
*Are you interested in Laser Vision Correction? Yes_____ No_____

PAST AND PRESENT MEDICAL HISTORY

Medication Allergies_____ Environmental Allergies_____
Current Medications_____
Previous Surgeries_____
Eye Medications_____

MEDICAL CONDITIONS (PATIENT)

	Yes	No		Yes	No
Thyroid disease			Respiratory		
Blindness			Fever/Weight Loss		
Heart Disease			Muscle/Bone/Joint		
Diabetes			Blood/Bleeding Disorder		
Kidney			Liver		
Hepatitis			Abdominal Problems		

High Blood Pressure	_____ _____	Genital / Urinary	_____ _____
Nervous Disorder	_____ _____	Ear/Nose/Mouth/Throat	_____
Psychological Disorder	_____ _____	Cancer	_____ _____
Cholesterol	_____ _____		

SOCIAL HISTORY

Smoking	_____ _____
Alcohol	_____ _____
Drugs	_____ _____

FAMILY HISTORY (RELATIVES, ie MOTHER,FATHER,GRANDPARENTS)

	Yes No		**Yes No**
Glaucoma	_____ _____	Heart Disease	_____ _____
Cataracts	_____ _____	Hypertension	_____ _____
Crosses/Lazy Eyes	_____ _____	Diabetes	_____ _____
Retinal Detachment	_____ _____	Blindness	_____ _____

MEDICARE, MEDICAID, BLUE CROSS BLUE SHIELD, VSP AND ALL OTHER INSURANCE PATIENTS/NON-INSURANCE PATIENTS:

" I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Administration (for Medicare patients) or to my insurance company and/or it's intermediaries, any information needed for related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment."

In the event of a denial or rejection of this claim by insurance company, I understand that the payment of said claim will be my responsibility.

ALL PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THE $35.00 REFRACTION FEE IF THAT IS NOT COVERED BY SAID INSURANCES.
I acknowledge that I was offered a copy of the Notice of Privacy Practices.

_____ Date_____

SIGNATURE OF GUARANTOR/PATIENT

I hereby give approval to disclose any or all of my medical information to:

NAME:_____ RELATIONSHIP_____

REFERRED BY: _____

For Doctors Use Only: Date_____ Reviewed by_____ No changes_____
Date_____ Reviewed by _____ No changes_____

Date_____ Reviewed by _____ No changes_____