Gainesville Family Eyecare

Patient Information

Name_____ Birth Date_____ Age_____ Sex: M or F Date_____

Address_____ Apt_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail_____

Occupation_____ Employer_____ Spouse's Name_____

How did you hear about our office? Yellow Pages Internet Insurance Another patient Other_____

Date of last exam_____ Name of previous Eye Doctor or name of office_____

Name of general physician_____ Name/Location of Pharmacy_____

In the past 7-10 days have you experienced any of the following? (Please check all that apply)

___Blurry Vision	___Double vision	___Flashing lights	___Itching
___Burning	___Eye Infection	___Floaters	___Redness
___Discharge	___Eye Injury	___Glare	___Tearing
___Dry Eye	___Excessive light sensitivity	___Headaches	___Twitching

Do you wear glasses? Y / N Do you wear contact lenses? Y / N If yes, what brand of contacts do you wear?_____

Do you sleep in your contacts? Y / N If you do not wear contacts, are you interested in being fit with contact lenses today? Y / N

Have you ever had any eye surgeries? Y / N If yes, please explain._____

Personal Health History. (Please check all that apply)

___Allergies/Hayfever	___Diabetes	___Kidney Disease	___Seizures/Epilepsy
___Arthritis	___Digestive Disorder	___Liver Disease	___STDs
___Blood Disorders	___Fibromyalgia	___Lupus	___Sinusitis
___Breathing Disorders	___Head Trauma	___Muscular Disorder	___Skin Condition
___Cancer	___Heart Condition	___Neurological Problem	___Stroke
___Chemical Dependency	___High Blood Pressure	___Psychological Disorder	___Thyroid Disorder

Other medical condition(s)_____

Do you smoke? Y / N If yes, please indicate how many packs per day?_____

Do you drink more than 4 alcoholic drinks per week? Y / N Are you currently pregnant? Y / N

Please list any medications you are currently taking, including eye drops._____

_____

Please list any medications you are allergic to: _____

Family History. (Please check all that apply)

___Blindness	___Diabetes	___High Blood Pressure	___Macular Degeneration
___Cataracts	___Glaucoma	___Lazy Eye/Crossed Eye	___Retinal Detachment

Please complete the other side of this form.

Insurance (if applicable)
(Please DO NOT write in the blank space below)

Primary Insurance	Secondary Insurance
Subscriber Name_____	Subscriber Name_____
Relationship to Patient_____	Relationship to patient_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Drs. Herlevich and Krol all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship	Date

Medicare Authorization (if applicable)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Herlevich and Krol at Gainesville Family Eyecare for any services rendered to me by these optometrists. I authorize any holder of medical information about me to release it to Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits for related services.

_____	_____
Signature of Beneficiary	Date