PATIENT INFORMATION

Patient Name_____
(LAST NAME) (FIRST NAME) MI JR,SR,ETC

Address_____City_____State_____Zip_____

Sex M____ F____ Age_____ Date of Birth_____ SS#_____

Occupation_____Patient Employer/School_____

Please list other family members who are living at home and their ages:_____

_____

Primary language written:_____spoken:_____

Race:_____ Hispanic/Latino origin Y / N

Height:_____ Phone numbers: Primary:_____ HOME/CELL/WORK

Weight_____ ____ Secondary:_____ HOME/CELL/WORK

Email address:_____

INSURANCE

Medical insurance:_____Policy#_____Group#_____

Vision insurance:_____Primary members SS#_____& DOB_____

Who is responsible for this account?_____Relationship to patient?_____

Assignment and Release I certify that I, and/or my dependents, have insurance coverage with the above listed insurance company and assign directly to Galvin Eyes, LLC 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 authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ Date_____
Signature of patient, parent, guardian, or personal representative

_____
Please print name of patient, parent, guardian, or personal representative

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of any Medicare benefits and, if applicable, Medigap benefits be made either to me or on my behalf to Galvin Eyes LLC, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits related services.

_____ Date _____
Signature of beneficiary,guardian, or personal representative

_____

For office use only Reviewed Date

EYE HEALTH HISTORY

Date of last eye exam_____
Do you wear glasses? Y / N
___All the time ___Occasionally
___Driving ___Reading ___TV

Do you wear contact lenses? Y / N

Type/Brand_____

Hours per day_____

Describe any problems you are having with your contact lenses_____

_____

If you do not wear contacts now, are you
interested in them? Y / N
Are you interest in LASIK/refractive surgery? Y / N
How many hours per day are you on the computer? _____
List any hobbies/sports played

_____

Are you having any of the following concerns:

Blurred distance vision	Y / N	Eye infection	Y / N
Blurred near vision	Y / N	Eye pain	Y / N
Burning eyes	Y / N	Eye strain	Y / N
Discharge from eyes	Y / N	Eye injury	Y / N
Watering eyes	Y / N	Headaches	Y / N
Light sensitivity	Y / N	Dry eyes	Y / N
Double vision	Y / N	Itching	Y / N
Poor night vision	Y / N	Red eyes	Y / N
Twitching eyelid	Y / N	Vision loss	Y / N
Floaters/spots	Y / N	Lazy eye	Y / N
Light flashes	Y / N	Eye surgery	Y / N

Do any of the following options appeal to you?

Thinner/Lightweight Lenses Y/N

Lenses that Darken Y/N

No-Line Bifocals Y/N

Anti-Glare Treatment Y/N

Contact Lenses Y/N

Laser Vision Correction Y/N

Scratch Resistant Coating Y/N

Sunglasses/Sun Clip Y/N

Safety glasses Y/N

Computer glasses Y/N

Sports glasses Y/N

Health History

Primary Physician's name_____ Date of last visit_____

Please circle "Yes" or "No" to indicate if you have any of the following. Also list any family members (mother,father,siblings,grandparents, etc) with following conditions.

Arthritis	Y/N _____	Skin conditions	Y/N _____
Asthma	Y/N _____	Bleeding conditions	Y/N _____
Emphysema	Y/N _____	Liver Disease	Y/N _____
Sleep apnea	Y/N _____	Stomach ulcer/reflux	Y/N _____
Tuberculosis	Y/N _____	Hay-fever/allergies	Y/N _____
High blood pressure	Y/N _____	Lupus	Y/N _____
High cholesterol	Y/N _____	Multiple Sclerosis	Y/N _____
Diabetes type (I,II)	Y/N _____	Sarcoidosis	Y/N _____
Pacemaker	Y/N _____	Cancer	Y/N _____
Congestive heart failure	Y/N _____	AIDS/HIV+	Y/N _____
Other heart conditions	Y/N _____	Hepatitis (type___)	Y/N _____
Kidney disease	Y/N _____	Cataracts	Y/N _____
Thyroid condition	Y/N _____	Macular degeneration	Y/N _____
Epilepsy/seizures	Y/N _____	Other retina problems	Y/N _____
Stroke	Y/N _____	Lazy eye	Y/N _____
Migraines	Y/N _____	Poor color vision	Y/N _____
Shingles	Y/N _____	Glaucoma	Y/N _____
Chemical dependency	Y/N _____	Blindness	Y/N _____

Psychological (anxiety,depression) Y/N _____

Other medical conditions (please describe)

_____

Women only:

Are you pregnant: Y/N

Are you nursing: Y/N

Do you drink alcohol: Y/N

Do you smoke: Y/N

Medications

Are you allergic to or have you had any reactions to the following?

(Please circle "yes" or "no" and describe type of reaction)

Local anesthetics	Y/N _____	Penicillin or other antibiotics	Y/N _____
Sulfa drugs	Y/N _____	Aspirin/Acetaminophen	Y/N _____
Other	_____		

List any prescriptions or over the counter medications you are taking, including eye drops:_____

_____

_____

Pharmacy name/Location _____