Goldthwait Vision Care

Welcome to our practice. Thank you for choosing us for your eye care needs. Please complete and sign this form for our records.

How did you hear about our practice?

- □ Yellow pages
- □ Radio advertisement
- □ Walk-in
- □ Internet search
- □ TV advertisement
- □ Other:____________________
- □ Patient referral
- □ Professional referral
- □ Current patient

□Mr. □Miss □Mrs. □Ms. □Dr. □Male □Female

Patient's First Name **MI** **Last Name** **Preferred Name**

Mailing Address **City/Town** **State/Zip**

____/____/____

Date of Birth **Home Phone** **Cell or Work Phone** **Social Security #**

E-MAIL ADDRESS: ______________________________ *(We will NOT share this address with any outside entity. It is for our internal use only)*

INSURANCE #1:______________________________**SUBSCRIBER:**______________________ **DOB:**__________

POLICY#______________________________**GROUP#**______________________________

INSURANCE#2:______________________________**SUBSCRIBER:**______________________ **DOB:**__________

POLICY#______________________________**GROUP#**______________________________

Subscriber's address if different than home address:______________________________

OCCUPATION: ☐ Student ☐ Retired ☐ Employed by ______________________

MARITAL STATUS: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

If patient is a minor, name of Parent or Guardian: ______________________________

Primary Care Physician: ______________________________ **Phone:** ______________

Acknowledgement of Receipt

I acknowledge that I have reviewed a copy of the Goldthwait Vision Care Notice of Privacy Practices (A copy is located on the bulletin board to the left of the receptionist window):

Patient Signature: ______________________________ Date: ______________

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Insurance Waiver

I, ______________________________, understand that all services performed on this date will be billed to my insurance company and that <u>ANY</u> charges that are <u>not</u> covered by my insurance will be my responsibility. I give my permission for this office to release my medical records to my insurance company to expedite any medical claims filed on my behalf. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Patient Signature: ______________________________ Date: ______________

(or signature of parent/guardian if patient under 18)

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Waiver for Self-Referred Services

I, ______________________________, understand that I am seeking the care of this specialty physician without a referral from my primary care physician. I understand that the terms of my health care coverage may require that I obtain a referral for specialty services and that I have <u>two weeks</u> to obtain a referral from my primary care physician or I may be responsible for all charges of the services rendered. I understand that benefits are subject to the terms, conditions, exclusions, and limitations of my plan documents, including my certificate of coverage or summary plan description.

Patient Signature: ______________________________ Date: ______________

(or signature of parent/guardian if patient under 18)

Goldthwait Vision Care
MEDICAL HISTORY QUESTIONNAIRE

Patient's name: ______________________ **DOB:** ______________ **Pt #** ______________

EYE HISTORY: **Last Eye Exam:** ______________ **with Dr.** ______________

Check box if you have had any of the following:

- ☐ Crossed eyes/Lazy eye
- ☐ Bulging eyes
- ☐ Glaucoma
- ☐ Drooping eyelid
- ☐ Eye infection
- ☐ Retinal disease
- ☐ Eye injury
- ☐ Cataracts
- ☐ Macular Degeneration

Have you ever had any eye surgery: **Y or N** If so, for what:______________________Year(s):________

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No Brand:______________ Power:__________Right __________Left

If you answered no, are you interested in wearing contacts? ☐ Yes ☐ No

REVIEW OF SYSTEMS: **Primary care physician's name:**______________________

Date of last exam:______________

EYES
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Retinal detach/disease
- ☐ Flashes/floaters in vision
- ☐ Loss of / blurred vision
- ☐ Distorted vision/halos
- ☐ Double vision
- ☐ Dryness
- ☐ Itching/burning
- ☐ Foreign body sensation
- ☐ Excess tearing/watering
- ☐ Glare/light sensitivity
- ☐ Eye pain
- ☐ Pink eye
- ☐ Styes/chalazion
- ☐ Sandy/gritty feeling

CONSTITUTIONAL
- ☐ Fever, weight loss/gain

CARDIOVASCULAR
- ☐ Heart disease/stroke
- ☐ High blood pressure
- ☐ Cholesterol

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Psychiatric

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid/other glands

EARS, NOSE, MOUTH, THROAT
- ☐ Allergies, hay fever
- ☐ Sinus congestion/post nasal drip
- ☐ Runny nose
- ☐ Chronic cough
- ☐ Dry throat/mouth

RESPIRATORY
- ☐ Asthma/chronic bronchitis
- ☐ Emphysema

INTEGUMENTARY
- ☐ Psoriasis

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY
- ☐ Genital/kidney, bladder disease

BONES, JOINTS, MUSCLES
- ☐ Rheumatoid arthritis
- ☐ Muscle pain
- ☐ Joint pain

LYMPHATIC/ HEMATOLOGIC
- ☐ Anemia/bleeding disorder
- ☐ Allergic/immunologic

FAMILY HISTORY: Please check any of the following conditions if there is a family history (parents, grandparents, siblings; living or deceased).

EYE:
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retinal detachment/disease
- ☐ Crossed eye

SYSTEMIC:
- ☐ Rheumatoid arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lupus
- ☐ Thyroid disease

SOCIAL HISTORY:

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

Do you have a history of alcohol abuse? ☐ Yes ☐ No

Do you currently use illegal drugs? ☐ Yes ☐ No Do you have a past history of illegal drug use? ☐ Yes ☐ No

Have you been exposed to/infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV ☐ None

MEDICATIONS:

Please list all medications you are taking, INCLUDING oral contraceptives, aspirin, hormone, and over-the-counter medications (or you can provide us with a medication list that we can photocopy):

______________ ______________ ______________ ______________
______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

Are you allergic to any medications? ☐ **No** ☐ **Yes If so what:**______________________

Patient Signature: ______________________________ **Date:** ______________