GIANNETTI
& RALSTON
Eye Care

Patient Information Today's Date: ____ / ____ / _____

First Name: _____ MI: ____ Last Name: _____ Preferred Name: _____

Date of Birth: ___ / ___ / _____ Social Security: ____ - ____ - _____ Preferred Language: _____

Gender: □ Male □ Female □ Other _____ Height: __ ft __ in Weight: _____ lbs Race: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Texting Available: □ Yes □ No

Email: _____

Preferred Method of Contact: □ Home □ Cell □ Work □ Email

Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer/School: _____ Occupation/Grade: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Last EYE Doctor/Location: _____ Date of last EYE exam: _____

Primary Care Physician/Location: _____ Date of last PHYSICAL exam: _____

Primary Care Physician Phone Number: _____

Pharmacy: _____ Location: _____

Names of Other Family Members Seen in Our Office: _____

Referred By: _____

Insurance Information:

Primary Medical: _____ Secondary Medical: _____

ID #: _____ Group #: _____ ID #: _____ Group _____

Vision Company: _____

ID #: _____ Group #: _____

SPECTACLE/CONTACT LENSES

Do you wear glasses? □ Yes □ No □ Full Time □ Part Time □ Distance Only □ Reading only □ Multifocal
How old are your current glasses? _____
Do you wear contact lenses? □ Yes □ No What Brand? _____
Are you interested in a new contact lens design? □ Yes □ No

COMPUTER USE

How many total hours per day do you use a computer, cell phone, tablet or play video games?
□ 0-2 hours □ 2-4 hours □ 4-6 hours □ more than 6 hours
Do you use computer glasses? □ Yes □ No
Are you interested in special glasses to make computer work easier? □ Yes □ No

SPORTS AND LEISURE:

What sports/hobbies do you participate in? _____
Do you wear any special eyewear for your sport/hobby? _____
Do you currently wear prescription sunglasses? □ Yes □ No Are you sensitive in bright lights? □ Yes □ No

What is the **MAIN reason** for your visit today? _____
Do you have any other visual/eye problems? _____

REVIEW OF SYSTEMS ***Are you currently experiencing any of the following symptoms?***

Category	Current Symptoms	Yes	No	Category	Current Symptoms	Yes	No	Category	Current Symptoms	Yes	No
Constitutional	Fever			***Genitourinary***	Burning while urinating			***Musculoskeletal***	Unexplained muscle pain		
	Unexplained Weight Loss/Gain				Difficulty urinating				Joint pain/restricted movement		
	Unexplained Fatigue or weakness				Blood in urine				Lower back pain		
Cardiovascular	Chest pain			***Head***	Sore throat			***Neurological***	Muscle weakness		
	Difficulties with exertion				Hearing loss				Tingling in extremities		
	Irregular heart beat				Hoarse voice				Dizziness		
Endocrine	Increased urination				Loss of smell				Dimming of vision		
	Increased thirst				Sinus congestion			***Psychiatric***	Ongoing depression or anxiety		
	Increased appetite			***Hematologic/ Lymphatic***	Swollen glands				Memory lapses		
Gastrointestinal	Constipation				Easy bruising				Disorientation		
	Diarrhea			***Integumentary (Skin)***	Unexplained skin rashes			***Respiratory***	Shortness of breath		
	Blood in stool				Itching of skin				Persistent cough		
	Heartburn				Pigmented area				Wheezing sounds		

MEDICATIONS *Please include all medications, including inhalers, contraceptive and over the counter*

□ **Please check here if NO medications**

Medication Name	Purpose	Dose	Medication Name	Purpose	Dose
Over-the-counter/Topical			**Eye drops**		

Are you currently on or have previously taken either of the following medications:

Tamsulosin (Flomax) □ Yes □ No

Hydroxychloroquine (Plaquenil) □ Yes □ No **If Yes** – current dose: _____

ALLERGIES

	Yes	No	Name of Medication/Other
Seasonal			
Allergies to Medications			
Other			

SOCIAL HISTORY

	Yes	No	Type and Frequency
Drink Alcohol			
Smoked in the past			
Currently smoke			
Recreational drug use			

EYE HISTORY

Condition	Self		Family	
	Yes	No	Yes	Relation
Eye Turn/Strabismus/Lazy Eye				
Cataracts				
Glaucoma/Suspect				
Macular Degeneration				
Retinal tear/detachment				
Dry eye				
Previous Eye Injury				
Other Eye Condition(s):				
Previous Eye Injection			**Type of Injection:**	
LASIK/Refractive Surgery			**Type of surgery:**	
Cataract Surgery			**Which eye:**	
Other Eye Surgeries			**Type of surgery/procedure:**	
Elective or other facial procedures			**Type of surgery/procedure:**	

MEDICAL HISTORY

Condition	Self		Family	
	Yes	No	Yes	Relation
Diabetes				
High blood pressure				
Elevated cholesterol				
Heart disease/heart attack				
Sleep Apnea				
Migraine				
Thyroid Disorder				
Stroke				
Cancer Type(s):				
Asthma/COPD				
Kidney Disease				
Arthritis, Type(s):				
History of COVID-19 Infection			Date of infection:	
Other:				
Pregnant - Currently				
Nursing - Currently				

Contact Release Information
I agree to permit Giannetti & Ralston Eye Care and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

Patient/Customer/Guardian Signature: _____

One Time Authorization (Medicare) Approved Form No.: OMB No. 0938-0222
I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Giannetti & Ralston Eye Care for any services furnished to me by the physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date Signed: _____
37-260 10/82 Revised (6/11) Form 514 (1/12)

One Time Authorization – Insurance Billing and Financial Policy
I request that payment of authorized Insurance Benefits be made on my behalf to Giannetti & Ralston Eye Care for any services furnished to me. I authorize release of any medical information concerning me to your company and its agents any information needed to determine these benefits or benefits payable for related services. I agree to pay this bill in full for any uncovered services by my insurance. I understand that payment for all services is expected at the time of service and I also understand that glasses and contact lenses must be paid in full prior to being dispensed.

Patient/Guardian Signature: _____ Date Signed: _____

Contact Lens Policy
I understand that contact lens services are an additional service to an eye examination. I agree to pay any fees associated with obtaining a contact lens prescription.

Patient/Guardian Signature: _____ Date Signed: _____

Acknowledgement of Receipt
I acknowledge that I have received a copy of the Notice of Privacy Practice and a copy of my rights regarding electronic health information exchange, for the office of Giannetti & Ralston Eye Care. Initial: _____

Authorization to Release Medical Information
(Please be advised that we cannot speak with anyone that is not listed on this form. This includes spouses, children and caregivers)

I am authorizing the personnel at Giannetti & Ralston Eye Care to leave medical information and test results with others if I am not available.

I do not wish to have any information released to anyone but myself. Initial: _____
OR
I authorize that my information can be left with:

□ Emergency Contact (listed on front page) □ Spouse: _____
□ Son/Daughter: _____ □ Other: _____

Patient or Guardian Printed Name: _____
Patient or Guardian Signature: _____ Date: _____