Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Patient ID:**

Last Name | Middle | First Name | Suffix | Preferred | DOB (mm/dd/yy) | SSN

Patient's Address | **Address Line 2** | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Country | Emergency Contact | Emergency Phone

Email | Person responsible for this A/C

Height ft in cm/m ☐ ft in ☐ cm ☐ m

Weight ☐ lbs ☐ kg

Authorized to discuss health info Name

Relationship to patient

Sex ☐ Male ☐ Female **Patient Status** ☐ Single ☐ Married ☐ Other **Student** ☐ Full Time ☐ Part Time **Employed** ☐

Race & Ethnicity

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African America
- ☐ Declined To Specify
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Not Hispanic or Latino

Preferred language

- ☐ English
- ☐ Spanish/Castilian
- ☐ Chinese
- ☐ Japanese
- ☐ Vietnamese
- ☐ Korean
- ☐ German
- ☐ French
- ☐ Declined To Specify
- ☐ Other

Primary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Country

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Zip

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you initially find our office? (Specify one)

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Giannetti & Ralston Eye Care. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Patient History and Information

Referring Physician

Physician 1 ☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D. ☐ Is Primary Care Physician

First Name	Middle	Last Name	Suffix	Clinic Name

Clinic Address	City	State	Zip	Phone

Physician 2 ☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D. ☐ Is Primary Care Physician

First Name	Middle	Last Name	Suffix	Clinic Name

Clinic Address	City	State	Zip	Phone

Health History

Reason for today's exam

When was your last exam? When was your last health exam?

Past illnesses or injuries

Past surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

Current Eye Symptoms

Glare Sensitivity	☐ Yes ☐ No	Foreign Body Sensation	☐ Yes ☐ No	Distorted Vision (Halos)	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Infection of Eye or Lid	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Light Sensitivity	☐ Yes ☐ No	Itching	☐ Yes ☐ No	Flashes	☐ Yes ☐ No
Tired Eyes	☐ Yes ☐ No	Mucous Discharge	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Burning	☐ Yes ☐ No	Drooping Eyelid	☐ Yes ☐ No	Fluctuating Vision	☐ Yes ☐ No
Dryness	☐ Yes ☐ No	Redness	☐ Yes ☐ No	Loss of Central Vision	☐ Yes ☐ No
Excess Tearing/Watering	☐ Yes ☐ No	Sandy or Gritty Feeling	☐ Yes ☐ No	Loss of Side Vision	☐ Yes ☐ No
Eyelid Swelling	☐ Yes ☐ No	Blurred Vision Distance	☐ Yes ☐ No	Loss Of Vision	☐ Yes ☐ No
Eye Pain or Soreness	☐ Yes ☐ No	Blurred Vision Near	☐ Yes ☐ No	Other	☐ Yes ☐ No

Eye History

Amblyopia (Lazy Eye)	☐ Yes ☐ No	Dry Eye Syndrome	☐ Yes ☐ No	PVD (Vitreous Detachment)	☐ Yes ☐ No
Infection of Eye or Lid	☐ Yes ☐ No	Eye Injuries	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Crossed Eyes	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Glaucoma Suspect	☐ Yes ☐ No	Keratoconus	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	High Risk Medication	☐ Yes ☐ No	Corneal Disease	☐ Yes ☐ No
Diabetic Retinopathy	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	Other	☐ Yes ☐ No

General Health Condition

Fever, Weight Loss, Fatigue, etc	☐ Yes ☐ No	Kidney, Bladder issues	☐ Yes ☐ No	Thyroid, Diabetes	☐ Yes ☐ No
Ears, Nose, Throat issues	☐ Yes ☐ No	Muscles, Bones, Joints issues	☐ Yes ☐ No	Blood (Cholesterol, Anemia, etc)	☐ Yes ☐ No
Cardiovascular (High BP etc.)	☐ Yes ☐ No	Skin (Rash, Itching, etc)	☐ Yes ☐ No	Allergic, Immuno	☐ Yes ☐ No
Respiratory (Asthma)	☐ Yes ☐ No	Neurological (Multiple Sclerosis)	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Gastrointestinal	☐ Yes ☐ No	Anxiety or Depression	☐ Yes ☐ No	Nursing	☐ Yes ☐ No

Medical History Questionnaire

Family History

Amblyopia (Lazy Eye)	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Cataract(s)	☐ Yes ☐ No	Strabismus (Eye Turn)	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Eye Tumors	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Others	☐ Yes ☐ No
Glaucoma Suspect	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No		

Social History

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 Per Day ☐ 2-3 Per Day ☐ 4+ Per Day

Smoking status

Tobacco use cessation intervention, counselling? ☐ Yes ☐ No

Tobacco use cessation pharmacologic therapy? ☐ Yes ☐ No

Do you use illegal drugs ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Use nutritional supplements (vitamins etc.)? ☐ Yes ☐ No

Current occupation Years

Employer

Hobbies/Interests

Spectacle Lens History

Do you use a computer? ☐ Yes ☐ No How many hours/day? Distance from Computer?

Do you drive? ☐ Yes ☐ No Mileage to work each way?

Do you have glare problems? ☐ Yes ☐ No

Visual difficulty when driving? ☐ Yes ☐ No

Problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Trouble in the past with glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No Are your sun glasses your current prescription? ☐ Yes ☐ No

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Occupational (mechanics, plumbers, pilots)

☐ Safety glasses (gardening, woodworking, welding)

☐ Sports/Hobbies (racquet sports, motorcycle)

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Type and brand of contact lenses

How many hours/day?

Reason for stopping?

Since

How many days/week?

Today's Wearing Time

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being Excellence

	Left	Right	What Solutions do you use?	
Lens comfort			Cleaner	
Distance vision			Disinfectant	
Near vision			Enzyme	

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 or Guardian Signature: _____ Date Signed:_____

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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 or 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. I acknowledge that my contact lens prescription will be provided to me at the completion of my contact lens fitting and evaluation.

Patient or Guardian Signature: _____ Date Signed:_____

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 authorize that my information can be left with:

__ Emergency Contact (listed on front page) __ Spouse: _____

__ Son/Daughter: _____ __ Other: _____

or

__ I do **not** wish to have any information released to anyone but myself.

Patient or Guardian Printed Name: _____

Patient or Guardian Signature: _____ Date Signed: _____