WELCOME to GREAT FALLS EYECARE, Optometrists!

PATIENT Information

Date:______________________________
Name: Mr. Mrs. Ms. Dr.
Last:______________________________
First:________________Middle initial_____
Address:___________________________
City:______________________________
State:______________ Zip:__________
Email:_____________________________
Home Phone:________________________
Cell Phone:________________________
Work Phone:________________________
Birthdate:____________Sex: M F
Occupation:________________________
Employer:__________________________
How did you hear about us?______________

IINSURANCE Information

Who is responsible for this account?________________
Relationship to Patient:____________Birthdate_________
Primary Medical Insurance Co.:____________________
Group #/ ID:____________________________
Secondary Medical Insurance Co:___________________
Group #/ ID:____________________________
Vision Insurance if separate:______________________
Group #/ ID:____________________________
Last 4 digits of primary's social sec #______; Patient's______

I authorize payment of benefits to Great Falls Eyecare. I agree to be financially responsible for any balance not paid by my Insurance plan. I authorize the use of my signature on all insurance submissions. Sign:______________________

Date:____________________

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Eye Health History

Date of last eye exam:________________
Do you wear glasses? YES NO
If so when do you wear them?__________
____
Do you wear contacts? YES NO
If so, type?_____________________
And hours/day?___________________
Have you had eye surgery? YES NO
If so, type and date?_______________
____
____
Are you using ANY kind of eye drops?
YES NO
If so, type?____________________
Hours on digital device/computer a day?_____

Place a mark on "Yes" or "No" if you have had the following:

Condition			Condition		
Burning eyes	Yes	No	Floaters or Spots	Yes	No
Blurred Vision- Distance	Yes	No	Glaucoma	Yes	No
Blurred Vision– Near	Yes	No	Headaches	Yes	No
Redness in Eyes	Yes	No	Itching Eyes	Yes	No
Cataracts	Yes	No	Light Sensitive	Yes	No
Color Vision, poor	Yes	No	Loss of Vision	Yes	No
Crossed Eyes	Yes	No	Migraines	Yes	No
Discharge from Eyes	Yes	No	Night Vision, poor	Yes	No
Double Vision	Yes	No	Seeing Halos	Yes	No
Dry eyes	Yes	No	Seeing Flashes	Yes	No
Chronic Eye infection	Yes	No	Loss of Side Vision	Yes	No
Eye Injury	Yes	No	Eye Pain	Yes	No
Eye Strain	Yes	No	Watering Eyes	Yes	No

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FAMILY Health History

Please note any family history (parents, siblings, grandparents, children; living or deceased) for the following conditions:

Condition			Relationship to you:
Blindness	Yes	No	
Cataract	Yes	No	
Crossed Eyes	Yes	No	
Glaucoma	Yes	No	
Macular Degeneration	Yes	No	
Retinal Disease	Yes	No	
Arthritis	Yes	No	
Cancer	Yes	No	
Diabetes	Yes	No	
Heart Disease	Yes	No	
High Blood Pressure	Yes	No	
Kidney Disease	Yes	No	
Lupus	Yes	No	
Thyroid Disease	Yes	No	
Other	Yes	No	

PLEASE COMPLETE BOTH PAGES

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with my doctor. (check box)

Are you pregnant or nursing? Yes No
Do you drive? Yes No
If yes, then do you have visual difficulty when driving? Yes No If yes, please describe:______________
____
Do you use tobacco products? Yes No If yes, type/ amount/ how long:____________________________
Do you drink alcohol? Yes No If yes, type/ amount/ how long:____________________________
Do you use illegal drugs? Yes No If yes, type/ amount/ how long:____________________________
Have you ever been exposed to or infected with Gonorrhea Hepatitis HIV Syphilis:____________

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Review of Systems: Do you currently suffer from any problems listed below? Yes or No

Constitutional
Fever, Weight Loss/Gain
Integumentary (Skin)
Neurological
Headaches
Migraines
Seizures
Endocrine
Thyroid/ other Glands
Bones/ Joints/ Muscles
Rheumatoid Arthritis
Muscle Pain
Lymphatic/ Hematologic
Anemia
Bleeding Problems
Allergic / Immunologic
Psychiatric

Ears, Nose, Mouth, Throat
Allergies/ Hay Fever
Sinus Congestion
Runny Nose
Post Nasal Drip
Chronic Cough
Dry Throat/ Mouth
Vascular / Cardiovascular
Diabetes
Heart Pain
High Blood Pressure
Vascular Disease
Gastrointestinal
Diarrhea
Constipation
Genitourinary
Genital/ Kidney/ Bladder

If you answered YES to any of the above or have a condition not listed, then please explain
____
____
LIST MEDICATIONS:____
____

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Please review the HIPAA regulations and sign / date that you have done so:

______________________________ ________________

PATIENT/ Guardian Signature **Date**

History Reviewed: DOCTOR Signature_______________ date_______

11/2015