Patient Information/History

Name_____ **Sex: M / F Today's Date**_____

Address_____ Zip_____ **Date of Birth**_____ **Age**_____

Email _____ **Date of Last Eye Exam**_____

Home Phone_____ **Date of Last Physica**l_____

Work Phone / Cell _____ **Current Occupation** _____

Medical History/Review of Symptoms

Please answer the following:
What is the reason for today's visit? (Chief Complaint)_____
Do you have any symptoms involving the eyes that we should be aware of today? (Itching, burning, floaters, flashes of light, etc) _____
Are you being treated for any medical condition/systemic disease? (Diabetes, high blood pressure, arthritis, HIV, etc)_____
Do you take any medications? (Include eye drops, birth control, vitamins, supplements, over the counter medications) _____
Do you or have you ever had any eye disease? (Glaucoma, cataracts, "lazy eye," retinal detachments, etc)_____
List any major surgeries/hospitalizations_____
Do you have any allergies? (Environmental, drug, etc.)_____
Do any medical or eye diseases run in your family? (Diabetes, high blood pressure, cancer, glaucoma, macular degeneration, retinal detachment, etc.)_____
Do you wear contact lenses? If so, what kind? (Include as much info as you know.)_____
If female, are you pregnant or nursing? Y / N How far along/post-partum?_____
Do you drive? Y/ N Any visual difficulty when driving?_____
Do you work on a computer? Y/ N How many hours per day?_____
FYI: The following information (and all information you provide) is strictly confidential and will not be shared but is required by some insurance companies that we inquire about the following 14 issues. The answers may or may not be relevant to the eye exam itself. If you prefer not to answer, initial here _____
Do you drink alcohol? Y / N Explain_____
Do you use tobacco products? Y / N Explain_____
Do you use recreational drugs? Y / N Explain_____
Have you ever been infected with HIV, hepatitis, gonorrhea, syphilis, herpes? Y / N _____
Do you CURRENTLY have any of the following: (If so, explain, if not, leave blank.)
Chronic fever, weight loss/gain, fatigue_____
Ear/Nose/throat problems (Hearing loss, sinus problems, sore throat)_____
Heart problems (Chest pain, etc)_____
Respiratory problems (wheezing, coughing, shortness of breath, etc)_____
Gastrointestinal problems (heartburn, abdominal pain, etc)_____
Urinary problems (Blood in urine, etc)_____
Skin problems (Rashes, dryness, etc)_____
Musculoskeletal problems (Muscle aches, joint pain, etc)_____
Neurological problems (Headaches, weakness, etc)_____
Psychiatric problems (depression, anxiety, etc)_____
Please list any other information you feel is relevant to your visit today_____

*****PLEASE COMPLETE INSURANCE AND PRIVACY INFORMATION ON SIDE 2*****

Medical/Vision Insurance Information

Patient name _____D.O.B._____SS#_____

Physician's Name_____ Physician's Phone_____

Primary Insurance_____ Patient's ID#_____

Primary cardholder_____ Relation to Primary Cardholder_____

Cardholder's Employer_____ Cardholder's D.O.B._____

Secondary Insurance_____ Patient's ID #_____

Cardholder_____ Relation to Cardholder_____

I request payment of insurance company and/or government benefits to Dr. Steven D. Gerber, Optometrist. I understand that I am responsible for providing Dr. Gerber with a copy of my current insurance card and a referral if required by the insurance plan. In case of a claim denial, I will assume full financial responsibility. I understand that contact lens fittings / evaluations are not insurance billable and are my full financial responsibility.

SIGNATURE:_____DATE:_____

Notice of Privacy Practices

You will have the right to read our posted "Notice of Privacy Practices" before you sign this copy. Our Notice provides a description of the uses and disclosures we may make of your protected benefits information (e.g. in order to bill insurance companies, call in prescription medications, or obtain referrals to other doctors).

I have been given the opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this consent form, I am giving consent to Dr. Gerber / Dr. Gerber's Eye Care to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

SIGNATURE:_____DATE:_____

*** If a parent or representative signs this Consent on behalf of the patient, complete below:

Parent/Representative's Name_____

Relationship to Patient_____

Dr. Gerber's Eye Care
Steven D. Gerber, O.D.
397 Cottage Grove Rd.
Bloomfield, CT

_____
Dr. Signature/Steven D. Gerber, O.D.

_____
Date