

AMERICAN | EYECARE

See. Life. Better.

Stacey Carabello, O.D. | Tod Gerhardt, O.D. | Abby Granera, O.D. | Logan Granera, O.D. | Matthew Ruhl, O.D.

Date: _____

Patient Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ Email: _____

SSN: _____ Male Female Birthdate: _____

Check the appropriate box: Minor Single Married Divorced Widowed Separated

Patient's or parents employer: _____ Work Phone: _____

Business Address: _____ City/State: _____

Occupation: _____ Visual demands? Distance Reading Computer Welding Power tools High speed objects

Emergency Information

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of person responsible for patient listed above: _____ Relationship to the patient: _____

Address: _____ Home Phone: _____ Birthdate: _____

Employer: _____ Work Phone: _____

Is this person currently a patient of our office? Yes No

HIPPA Authorization & Release of Medical Information

I authorize release of any information concerning myself, or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the doctor(s) today and in the future.

I acknowledge that I was offered/received a copy of American Eyecare's Notice of Privacy Practices. (If patient is under guardianship, legal guardian should sign as well).

Signature of patient or parent/guardian if a minor. Date.

Authorized to Access Medical Records Initial

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If we can do anything special for you
Please ask!

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Medical Information

Social History

Do you vape? No Yes Do you smoke? No Yes _____pkg/day Alcohol consumption____/day social only Are you pregnant? No Yes

Have you ever been infected with a communicable disease? No Yes Explain: _____

Review of Eye Health

Have you ever been diagnosed with any of the following: Cataract Glaucoma Retinal detachment No known eye conditions

If you suffer from any other eye conditions, please list: _____

Please list eye surgeries and the dates of those surgeries, if any: _____

Family Medical Doctor: _____ **Pharmacy:** _____ **Medication Allergies:** _____

Medical History

- No Current Health Conditions ADHD Anxiety Arthritis Asthma Bipolar Disorder Cardiac Arrest
 Chest Pain Congestive Heart Failure COPD Cancer Dementia Depression Diabetes Type 1 Diabetes Type 2
 Prediabetes Disorder of Endocrine System Eczema Hypocholesteremia/High Cholesterol Heart Disease Lupus
 Hypertension/High Blood Pressure Hyperthyroidism Hypothyroidism Kidney Disease Seizures Stroke

Other: _____

Medication

<u>Medication</u>	Dosage	<u>Medication</u>	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: (Please check which of the following, if any, your immediate blood relatives have been diagnosed with)

- Blindness Cataract Crossed eyes Glaucoma Macular degeneration Retinal detachment Lupus
 Diabetes Heart Disease High blood pressure Kidney disease Thyroid disease Cancer

Other: _____