AMERICAN | EYECARE

See. Life. Better.

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

Date:_____

Patient Name:_____ Phone:_____
First Middle Last

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!

AMERICAN | EYECARE

See. Life. Better.

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

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	Dosage	**Medication**	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:_____