



Patient Information

Name _____ Birth Date _____ Age _____ Sex: M or F Date _____
Address _____ Apt _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____
Occupation _____ Employer _____ Spouse's Name _____
How did you hear about our office? Yellow Pages Internet Insurance Another patient Other _____
Date of last exam _____ Name of previous Eye Doctor or name of office _____
Name of general physician _____ Name/Location of Pharmacy _____

In the past 7-10 days have you experienced any of the following? (Please check all that apply)

- Blurry Vision
- Double vision
- Flashing lights
- Itching
- Burning
- Eye Infection
- Floaters
- Redness
- Discharge
- Eye Injury
- Glare
- Tearing
- Dry Eye
- Excessive light sensitivity
- Headaches
- Twitching

Do you wear glasses? Y / N Do you wear contact lenses? Y / N If yes, what brand of contacts do you wear? _____
Do you sleep in your contacts? Y / N If you do not wear contacts, are you interested in being fit with contact lenses today? Y / N
Have you ever had any eye surgeries? Y / N If yes, please explain. _____

Personal Health History. (Please check all that apply)

- Allergies/Hayfever
- Diabetes
- Kidney Disease
- Seizures/Epilepsy
- Arthritis
- Digestive Disorder
- Liver Disease
- STDs
- Blood Disorders
- Fibromyalgia
- Lupus
- Sinusitis
- Breathing Disorders
- Head Trauma
- Muscular Disorder
- Skin Condition
- Cancer
- Heart Condition
- Neurological Problem
- Stroke
- Chemical Dependency
- High Blood Pressure
- Psychological Disorder
- Thyroid Disorder

Other medical condition(s) _____
Do you smoke? Y / N If yes, please indicate how many packs per day? _____
Do you drink more than 4 alcoholic drinks per week? Y / N Are you currently pregnant? Y / N
Please list any medications you are currently taking, including eye drops. _____

Please list any medications you are allergic to: _____

Family History. (Please check all that apply)

- Blindness
- Diabetes
- High Blood Pressure
- Macular Degeneration
- Cataracts
- Glaucoma
- Lazy Eye/Crossed Eye
- Retinal Detachment

Please complete the other side of this form.

Insurance (if applicable)

(Please DO NOT write in the blank space below)

Primary Insurance

Secondary Insurance

Subscriber Name _____

Subscriber Name _____

Relationship to Patient _____

Relationship to patient _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Drs. Herlevich and Krol all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Medicare Authorization (if applicable)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Herlevich and Krol at Gainesville Family Eyecare for any services rendered to me by these optometrists. I authorize any holder of medical information about me to release it to Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits for related services.

Signature of Beneficiary

Date