GINTER EYECARE CENTER

5713 82nd Street, Lubbock, Texas 79424
(806) 798-8820
www.gintereyecarecenter.com

WELCOME

Thank you for selecting our practice for your eye care needs. Please use ink to complete the following information on the front and back of this questionnaire. If you have any questions, do no hesitate to ask for assistance; we will be happy to help you.

TODAY'S DATE: _____/_____/_____
Mo Day Yr

PATIENT INFORMATION

Name: _____ _____ _____
Last First Middle

Minor Single Married Widowed

Address: _____

_____
City State Zip

DOB:_____/_____/_____ Age: _____ Male / Female
Mo Day Yr

Phone #: (Hm/Wk/Mob) (_____)_____-_____

2nd Ph#: (Hm/Wk/Mob) (_____)_____-_____

If we need to contact you, which # would you prefer us to call? (Hm/Wk/Mob/Please do not contact me)

Email _____

S.S. Number _____-_____-_____

Occupation: _____

Employer: _____

Emergency contact information

Name: _____

Relationship: Spouse/Parent/Other_____

Phone #: (_____) _____ - _____

New Patients: Whom may we thank for referring you?

_____

How did you select our office? Yellow pages/ insurance/tv/web site/sign

VISION INSURANCE INFORMATION

Vision Insurance Co: _____

Insurance ID#: _____

Group #: _____

Name of Insured: _____

Relationship: self/spouse/child/other _____

Insured's DOB: _____

Insured's Add: _____

Insured's Ph#: (_____)_____-_____

Insured's Employer: _____

Employer's Ph #: (_____)_____-_____

MEDICAL INSURANCE INFORMATION

Medical Insurance Co: _____

Insurance ID#: _____

Group #: _____

Name of Insured: _____

Relationship self/spouse/child/other _____

Insured's DOB: _____

Insured's Add: _____

Insured's Ph #: (_____)_____-_____

Insured's Employer: _____

Employer's Ph #:(_____)_____- _____

Please present <u>all insurance cards</u> at front desk for a photocopy to be put in your record, which is required by your insurace at each visit

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge.
The questions on front and back of this questionnaiare have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor of ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services, and not all services may be covered by my insurance such as screening photos, refraction, contact lens fittings, deluxe frames and lens add ons. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE

<u>CONFIDENTIAL DOCUMENT</u>

(Please complete both sides)

TO BETTER SERVE YOU WE HAVE AN IN-HOUSE LAB
MOST ORDERS CAN BE DONE THE <u>SAME DAY</u>

GINTER EYECARE CENTER, INC.

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Thank you for taking the time to answer this questionnaire. The information provided will assist your doctor in giving you the best comprehensive eye care available.

What is the reason for today's exam?
Y N Yearly health exam
Y N Eye infection
Y N LASIK/PRK evaluation
Y N Remove foreign body from eye
Other: _____

OCULAR/EYE INFORMATION

Do you have any of the following?
Y N Blurred vision at distance
Y N Blurred vision at near
Y N Eye strain with computer use
Y N Itchy eyes
Y N Red eyes
Y N Dry eyes
Y N Watery eyes
Y N Eye pain
Y N Double vision
Y N Light sensitivity
Y N Floaters
Y N Flashes of light

Do you wear or need:
Y N Glasses
Y N Contact lenses (circle type)
Gas Perm/Hard
Soft
Bifocal
Color/ enhancer
Disposable
Overnight wear

Have you ever had any of the following? Explain
Y N Eye infection _____
Y N Eye injury/surgery _____

Have you ever been told you have any of the following?
Y N Glaucoma
Y N High Pressures in your eyes
Y N Cataracts
Y N Macular Degeneration
Y N Retinal holes/tears/degeneration
Y N Keratoconus
Y N Blindess
Y N Any other eye problems not listed: _____

ALLERGY INFORMATION

Y N Are you **allergic** to any medication(s)
(If yes, list name of medication and reaction)
_____
_____

Y N Do you have any seasonal/environmental allergies?
_____

WOMEN ONLY

Y N Are you pregnant/nursing?

Patient History Information (Confidential)

MEDICAL INFORMATION

Do you have any of the following?
Y N High Blood Pressure
Y N Heart disease
Y N Diabetes (Type I/ Type II)
Y N High Cholesterol
Y N Asthma
Y N Headaches
Y N Arthritis
Y N MS
Y N Lupus
Y N AIDS
Y N Cancer
Y N Other (please describe):_____

Do you have problems with any of these systems?
Y N Nervous
Y N Mental
Y N Respiratory
Y N Musculoskeletal
Y N Gastrointestinal
Y N Genitourinary
Y N Endocrine/Thyroid
Y N Blood/Lymph
Y N Integument (skin)
Y N Ears/Nose/Throat

MEDICATIONS - List all you currently taking:
(Include aspirin/ vitamins/ hormones/ birth control)
_____
_____
_____

Pharmacy Name _____
Address _____

Y N Have you had any operations/ hospitalizations? Explain

Do you:
Y N Smoke/Use tobacco?
Y N Use alcohol?
Y N Use recreational drugs?

Name of Last Eye Doctor_____
Date of last eye exam_____
Last dilated exam _____
Name of Family Physician_____
Date of last exam _____
Phone number _____
Last Tetanus shot _____

FAMILY HISTORY

Does anyone in your family have any of the following conditions? If yes, **whom**? (Father, Mother, Sibling, Grandparent, Children, etc)
Y N High blood pressure _____
Y N Heart disease _____
Y N Diabetes _____
Y N Cancer _____
Y N Glaucoma _____
Y N Cataracts _____
Y N Macular degeneration _____
Y N Retinal problems _____
Y N Blindness (partial or total) _____
Y N Other medical/ocular condition not listed_____
_____

DOCTOR USE ONLY

Reviewed by_____ ☐ No changes Date _____
Reviewed by_____ ☐ No changes Date _____
Reviewed by_____ ☐ No changes Date _____

It is a requirement for Eye Healthcare Providers to include the following information in the patient's Eye Healthcare Chart. Thank you for providing your complete information.

NAME_____ **DATE**_____

HEIGHT_____ **WEIGHT**_____ **BLOOD PRESSURE**_____

If you are unsure we would be happy to check your height, weight and blood pressure for you.

Please Circle One:

RACE: American Indian or Alaska Native

Asian

Black or African American

Hispanic

Native Hawaiian or other Pacific Islander

White

Other_____

ETHNICITY: Hispanic or Latino

Native Hawaiian/Pacific Islander

Not Hispanic or Latino

FOR OUR RECORDS PLEASE LET US KNOW HOW YOU WOULD PREFER TO BE CONTACTED:

***PLEASE FILL IN ALL THAT APPLY**

CALL: HOME _____ **CELL** _____ **WORK** _____

TEXT _____

EMAIL_____

MAIL _____

☐ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.

WHOM MAY WE SHARE YOUR MEDICAL INFORMATION WITH:

***PLEASE FILL IN ALL THAT APPLY**

SPOUSE _____

CHILD _____

PARENT/GUARDIAN _____

OTHER _____

I acknowledge that I have received a copy of GINTER EYECARE CENTER Notice of Privacy Practices.

Patient name _____

Signature _____ **Date** _____