

PATIENT INFORMATION

Thank you for choosing Iverson-Tomasino-Goerss Eyecare Associates for all of your eye care needs. Please complete both sides of this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help in any way possible. (Please Print)

Name _____ Date _____ Social Security # _____
FIRST MI LAST E-mail Address: _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Home Ph # _____ Work Ph # _____ Cell Ph # _____
Nickname _____ Do you prefer to receive calls at: Home Work Cell No Preference
Are you: Married Single Minor Divorced Widowed Separated
You or your parent's employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Workplace _____ Work Phone # _____
If you are a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone# _____
When was your last eye examination? _____ Place of service/Doctor? _____
Would you like new glasses today? yes no would consider **Would you like new contacts today?** yes no
Are you interested in LASIK? yes no would consider

RESPONSIBLE PARTY

Name of person responsible for this account: Name _____ Social Security # _____
Relationship to patient _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work phone # _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____
DO YOU HAVE ADDITIONAL INSURANCE? No Yes **IF YES PLEASE COMPLETE THE FOLLOWING:**
Name of insured _____ Relationship to patient _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

SOCIAL HISTORY

This information is kept strictly confidential. However, if you prefer to discuss this directly with the doctor please check the following box:

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe: _____
Do you use tobacco products? No Yes If yes, type/amount/for how long: _____
Do you drink alcohol? No Yes If yes, type/amount/for how long: _____
Do you use illegal drugs? No Yes If yes, type/amount/for how long: _____
Have you been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Chlamydia None
What hobbies or sports do you participate in? _____
Do you work at a computer or video display terminal? No Yes If yes, how many hours/day: _____

MEDICAL HISTORY

Do You have any allergies to medications? No Yes If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

List all major injuries, surgeries, and/or hospitalization you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury? _____

Are you pregnant or nursing? No Yes

Visual correction: glasses How old is current pair? _____ contact lenses How old is current pair? _____

Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? yes no

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions and list the relationship of the family member to you:

<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Cataract _____	<input type="checkbox"/> Crossed eyes _____
<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Macular degeneration _____	<input type="checkbox"/> Retinal disease _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Lupus _____	<input type="checkbox"/> Thyroid Disease _____	<input type="checkbox"/> Other? _____

REVIEW OF SYMPTOMS

Do you currently, or have you ever had any problems in the following systems: (If yes, please explain)

SYSTEM	NO	YES	EXPLAIN
Constitutional: (fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary: (skin)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological: (headaches, migraines, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes:			
Loss of Vision / Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness / Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness / Itching / Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain / Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare / Halos / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes / Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat, Mouth:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory: (asthma, chronic bronchitis, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular/Cardiovascular: (high blood pressure, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal: (diarrhea, constipation)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary: (genitals, kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones / Joints / Muscles: (arthritis, muscle or joint pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic / Hematologic: (anemia, bleeding problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine: (thyroid, other gland dysfunction)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic / Immunologic:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric:	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify that I have read and answered the above questions to the best of my knowledge. I authorize the eye doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child 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 or Iverson-Tomasino-Goerss Eyecare Associates any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and materials. I agree to be responsible for payment of all services and materials rendered on my behalf or my dependents.

PATIENT SIGNATURE

DATE

DOCTOR SIGNATURE

DATE