**Welcome to Griswold Eye Care!** We appreciate your time in answering the questions on this form. Your overall health relates to your eye health so each section is important. Thank you!

___Mr. ___Mrs. ____ Ms. ____Other:_____ Preferred Pronouns: He/Him She/Her They/Them Other:_____

_____ _____ _____ _____
First Name MI Last Name Preferred Name

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____ Texting? **YES** / **NO**
Social Security Number Date of Birth Primary Phone Number

_____ _____
Email Address Other Phone Number (optional)

_____ I consent to my glasses and/or contact lens **prescription** being e-mailed to me if I request it and I
Initials
acknowledge it is **not HIPAA compliant**.

Emergency Contact: _____ Relationship: _____ Phone:_____
Name

**PRIMARY INSURANCE:**
Relation to Primary Insured: Self / Spouse / Child / Parent / Other: _____

Name of Insurance Company: _____

Insurance ID Number: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN (If Applicable): _____

**SECONDARY INSURANCE (If Applicable):**
Relation to Primary Insured: Self / Spouse / Child / Parent / Other: _____

Name of Insurance Company: _____ Insurance ID Number: _____

Policy Holder's Name: _____ Date of Birth: _____ Policy Holder's SSN: _____

**HIPAA POLICY: Please read carefully.**
I agree to allow my medical information be shared with my insurance company for the sole purpose of billing and to any healthcare provider necessary for continuity of care.
I acknowledge that I am aware that Griswold Eye Care has a notice of privacy practices available to me at all times during normal business hours. I fully understand that I am protected under HIPAA and will be required to sign a release for any and all medical records.

_____ _____
Signature of Patient/Legal Guardian Date

**OFFICE POLICY: Please read carefully.**
In order to control the cost of billing we require that the patient's portion of costs is due at the time of services rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. All accounts with unpaid bills after 90 days are subject to collection fees. There will be a service charge on all returned checks. We require at least 24 hours notice for any cancelations or rescheduled appointments in order to be fair to our other patients. **Any late cancellations or missed appointments are subject to a $50 fee.** I acknowledge and accept the above policies.

_____ _____
Signature of Patient/Legal Guardian Date

**RACE:** (Circle all that apply): Asian / White / Hispanic (Latino) / Black (African American) / Native American /

Other: _____ / Declined to Specify

**PRIMARY CARE PHYSICIAN:** _____ CLINIC NAME: _____

_____ _____

Office Address Phone Number

## HEALTH HISTORY

Main Reason for Today's Exam: _____Last Eye Exam: _____

Last Physical Exam: _____ Height: _____ Weight: _____ Are you pregnant or nursing? **YES NO**

Past or Current Illnesses or Injuries: _____ _____

Current Medications (Attach list if needed):

_____

_____

Past Eye/Brain Surgeries (if applicable): _____ _____

Current Eye Drops: _____

Allergies/Sensitivities to Medications: _____

Specific Allergies: _____

## HAVE YOU HAD THE COVID-19 VACCINE? YES NO Sign_____

## SOCIAL HISTORY

Current Occupation: _____Years: ____ Employer: _____

Do you: Smoke Cigarettes **YES NO** Drink Alcohol **YES NO** Other: _____

## EYE HISTORY

| Do you Have… | YES | NO |
|---|---|---|
| Blurry Vision at Distance without glasses? | | |
| Blurry Vision at Near without glasses? | | |
| Floaters? | | |
| Eye Pain? | | |
| Dry, gritty or burning sensation of the eye? | | |
| Amblyopia (Lazy eye)? | | |
| Macular degeneration? | | |
| History of eye surgery? | | |
| History of retinal detachment? | | |
| History of ocular trauma? | | |
| Glaucoma? | | |
| Color Blindness? | | |

## MEDICAL HISTORY

| Have you been diagnosed with.. | YES | NO |
|---|---|---|
| High Blood pressure? | | |
| Diabetes? | | |
| High cholesterol? | | |
| HIV or AIDS? | | |
| Arthritis? | | |
| Asthma? | | |
| COPD or Lung problems? | | |
| Thyroid condition? | | |
| History of Stroke? | | |
| Use a CPAP machine? | | |
| Other medical conditions? (list below) | | |
| | | |

## FAMILY HISTORY

Unknown ☐

| | YES | NO | If Yes Who? |
|---|---|---|---|
| Macular Degeneration | | | |
| Glaucoma | | | |
| Color Blindness | | | |
| Blindness | | | |
| Diabetes | | | |
| Cancer | | | |
| High Blood Pressure | | | |
| Thyroid | | | |
| Other | | | |

## GLASSES HISTORY (Circle all that apply)

**Have you ever worn glasses? YES NO** **Do you currently wear glasses? YES NO**

If yes→ Type of glasses worn? Distance / Reading / Bifocals / Progressives (No Line Bifocal)

**Have you ever worn contact lenses? YES NO** **Do you currently wear contact lenses? YES NO**

If yes→ Brand/Type of contact lenses: _____