

Welcome to our office

Everything  Eyes

DRS. GARMIZO & DeCANIO

**Board Certified Optometric Physicians
Fellows, American Academy of Optometry**

PATIENT INFORMATION

PERSONAL

Mr.____ Mrs.____ Ms.____ Dr.____ Today's Date_____

Full Name_____ SS# _____ / _____ / _____
Last First Initial

Address_____ Home Phone _____ Cell Phone _____
Street Unit #

_____ Email _____
City State Zip

Employer _____ Occupation _____ Work Phone _____

Sex _____ Birth Date _____ Emergency Contact _____ Phone _____

GENERAL

How did you learn about our office? Newspaper Internet Television Yellow Pages

A Friend or Relative Walk/Drive By Insurance Company/Third Party Administrator Other

Referred by another Patient.....If so, whom may we thank_____

Do you have any interest in LASER vision correction? Yes No

Reason for this visit: Eye Examination Contact Lens Exam

LASER / Surgery Consultation _____ New Eyewear Other _____

HEALTH (Please check all that apply.)

Are you currently taking any medications? Yes No (Include eye drops, hormones, & birth control)

Please list any medications: _____

Are you allergic to any medications? Yes No if so, please list _____

Have you ever had any injury to or around your eyes? Yes No

Please describe _____

Last eye exam _____

Do you experience computer eyestrain? Yes No

PLEASE TURN OVER 

FAMILY HEALTH HISTORY (Please check all that apply.)

	You	Blood Relative		You	Blood Relative
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Vascular Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal/Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis/Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

RESPONSIBLE PARTY

Name of person responsible for this account _____ D.O.B _____

Social Security # _____ Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work # _____

PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARDS FOR PRIMARY AND SECONDARY INSURANCE.

Please check the method of payment for today's professional services

_____ Cash

_____ Check

_____ Credit Card

Signature

I request that payment of authorized **Medicare, Medicaid, or other insurance benefits** be made to me or on my behalf to Everything Eyes, and/or any of its affiliates, for any services furnished me. Claims are filed to my insurance as a courtesy and I am responsible for any amount not paid by them. I authorize any holder of medical information about me, to release to the health care financing administration and its agents, any information needed to determine these benefits payable for related services.

Lifetime Patient Signature _____ Date: _____