Welcome to our office

DRS. GARMIZO & GOLCHIN

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 Vision Plan ☐ 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

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____________________ Doctor/Location__________________________
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	☐	☐	Diabetes	☐	☐
Cataracts	☐	☐	High/Low Blood Pressure	☐	☐
Lazy Eye	☐	☐	Heart/Vascular Disorder	☐	☐
Blindness	☐	☐	Thyroid Condition	☐	☐
Allergies	☐	☐	Cancer/Tumors	☐	☐
Color Blindness	☐	☐	Retinal Disease	☐	☐
Intestinal/Digestive Disorder	☐	☐	Asthma/Bronchitis/Lung Disorder	☐	☐
Kidney/Liver Disorder	☐	☐	High/Low Blood Sugar	☐	☐
Arthritis	☐	☐	Do you wear contact lenses?	☐ Yes	☐ No
Fainting/Dizziness	☐	☐	Are you Pregnant?	☐ Yes	☐ 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: ___________________________