

# Welcome

## Thank you for choosing Granger Family Eyecare

(We care. You'll see.)

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please advise if you do not want calls at your work unless in an emergency

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Vision Benefit(Insurance)and Payment Information

Do you have a vision benefits program Yes \_\_\_ No \_\_\_

Plan Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Birth Date: \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

I authorize the release of any medical or other information necessary for the purpose of evaluating and administering claims for insurance benefits (see notice of Privacy Practices). I also hereby authorize payment of insurance benefits directly to Granger Family Eyecare, Inc. for services performed at this practice. The patient agrees to be responsible for payment of any service not covered by their vision benefit plan. Furthermore, patient agrees to be responsible for all collection costs, attorney fees and court costs should legal action be necessary to collect on your account. Your account will be charged 18% APR on unpaid balances after 30 days.

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or authorized person

### Responsible Party

\_\_\_ Same as above \_\_\_ Shown below

Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Privacy Policy, Acknowledgement of Receipt

In accordance with the U.S. Department of Health and Human Services and the Federal Health Insurance Portability and Accountability Act, all patient information is strictly confidential and protected by law. All patient information is strictly confidential and protected by law. Any and all patient information will only be used for purposes directly related to patient treatment, payment, or management/health care operations. Your signed authorization is required on a separate document only if information is to be shared for purposes other than those stated above.

I acknowledge that I received a copy of Granger Family Eyecare's Notice of Privacy Practices: X \_\_\_\_\_ Date: \_\_\_\_\_

10/07 ed.

**GRANGER FAMILY EYECARE  
PATIENT HEALTH HISTORY**

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

Your medical doctor's name and location \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

**Yes**    **No**    **?**    **PERSONAL EYE HISTORY**    **Date of last eye exam** \_\_\_\_\_

- Eye Surgeries \_\_\_\_\_
- Eye Injuries \_\_\_\_\_
- Glaucoma
- Cataracts
- Dry Eyes
- Macular Degeneration
- Retinal Detachment or Tear
- Crossed or Lazy Eye

**DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?**

- Loss of Vision
- Blurred, Fluctuating, or Distorted Vision
- Double Vision
- Eye Pain or Discomfort
- Sandy or Gritty Feeling, Burning Eyes, or Foreign Body Sensation
- Excess Tearing
- Mucus Discharge
- Tired Eyes
- Sensitivity to Light or Glare
- Redness
- Itching
- Drooping Eyelid

**GLASSES AND CONTACT LENS HISTORY**

- Do you wear    glasses    and/or    contact lenses?
- Are you interested in contact lenses    colors    bifocals?
- Do you wear    sunglasses or    safety glasses?

**SOCIAL HISTORY**

Occupation \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_

- Yes**    **No**
- Do you use tobacco products?
- Do you drink alcohol?
- Do you use illegal drugs?
- Are you exposed to occupational chemicals?
- Do you drive? Any problems associated with driving? \_\_\_\_\_

**OVER**

NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

- | Yes                   | No                    | ?                     | PERSONAL MEDICAL HISTORY  |
|-----------------------|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Lung Disease: <input type="radio"/> Asthma <input type="radio"/> TB <input type="radio"/> Shortness of Breath <input type="radio"/> Emphysema<br><input type="radio"/> Other _____                              |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Heart Disease: <input type="radio"/> Congestive Heart Failure <input type="radio"/> Pace Maker <input type="radio"/> Heart Attack<br><input type="radio"/> Angina <input type="radio"/> Other _____             |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High Blood Pressure   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High Cholesterol  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes: <input type="radio"/> Diet and Exercise <input type="radio"/> Oral <input type="radio"/> Insulin; Year Diagnosed: _____   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Neurological Disease: <input type="radio"/> Stroke <input type="radio"/> Seizures <input type="radio"/> MS <input type="radio"/> Headaches<br><input type="radio"/> Migraines <input type="radio"/> Other _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Thyroid Disease   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cancer: Type _____ Year _____ <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> Surgery   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Arthritis   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Urinary/Prostate Disorders  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Stomach/Intestine Disorders   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Immune System Disorders: <input type="radio"/> Allergies <input type="radio"/> Lupus <input type="radio"/> Hepatites <input type="radio"/> HIV + <input type="radio"/> AIDS<br>Other _____                      |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Skin: <input type="radio"/> Acne <input type="radio"/> Skin Cancer  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Psychiatric: <input type="radio"/> Anxiety <input type="radio"/> Depression <input type="radio"/> Insomnia  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ear, Nose, Throat: <input type="radio"/> Sinus <input type="radio"/> Ear Infections <input type="radio"/> Chronic Cough   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | General/Constitutional: <input type="radio"/> Fever <input type="radio"/> Weight Loss/Gain  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever had a blood transfusion?  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | (Women) Are you pregnant or nursing?  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Have you ever fainted during an eye examination?  |

PLEASE LIST ALL PRESCRIPTION AND OTC MEDS, VITAMINS, NUTRITIONAL/ HERBAL SUPPLEMENTS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO MEDICINES? YES NO PLEASE LIST DRUG AND REACTION: \_\_\_\_\_

- | Yes                   | No                    | ?                     | FAMILY HISTORY       | Yes                   | No                    | ?                     |                      |
|-----------------------|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|-----------------------|----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Glaucoma             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | HeartDz/Hypertension |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cataracts            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes             |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Macular Degeneration | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cancer               |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Crossed or Lazy Eye  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Migraine Headaches   |

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

DOCTORS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Tara L. Svatos, O. D.

M. Walker Jr., O.D.