



GADDIE EYE CENTERS

40 YEARS OF 20/20 VISION

PATIENT INFORMATION SHEET (PLEASE PRINT)

NAME _____ (PARENT IF MINOR _____)

ADDRESS _____ Last First Initial CITY _____ STATE __ ZIP _____

PHONE: HOME _____ WORK _____ E-MAIL _____

DATE OF BIRTH _____ SS# _____

PLACE OF EMPLOYMENT & POSITION _____

OR SCHOOL & YEAR _____

DATE OF LAST EYE EXAM _____ PREVIOUS DR. _____

REFERRED BY: NAME _____

SPOUSE'S NAME _____ SS# _____

PLACE OF EMPLOYMENT _____

PRESCRIPTION INFORMATION

CURRENTLY WEAR GLASSES? _____ CONTACTS? _____

WOULD YOU LIKE TO BE EVALUATED FOR CONTACT LENSES AND/OR WANT MORE INFORMATION ABOUT CONTACT LENSES? _____

I UNDERSTAND THAT PRESCRIPTION SERVICES ARE VALID FOR ONE YEAR.

ARE YOU INTERESTED IN LASER VISION CORRECTION? _____

FAMILY HEALTH HISTORY

PLEASE CHECK YES OR NO, THEN WHICH FAMILY MEMBER

	YES	NO	RELATIVE		YES	NO	RELATIVE
RETINAL DETACHMENT	___	___	_____	CATARACT	___	___	_____
BLINDNESS	___	___	_____	CANCER	___	___	_____
GLAUCOMA	___	___	_____	DIABETES	___	___	_____
MACULAR – DEGENERATION	___	___	_____				

Please complete next page

PATIENT HEALTH HISTORY

PLEASE CHECK IF YOU'VE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
CATARACT SURGERY	___	___	LUNG PROBLEM	___	___
LASER SURGERY	___	___	STOMACH PROBLEM	___	___
RETINAL DETACHMENT	___	___	KIDNEY PROBLEM	___	___
GLAUCOMA	___	___	ARTHRITIS	___	___
REFRACTIVE SURGERY	___	___	SLEEP APNEA	___	___
EYE INJURY	___	___	MIGRAINE HEADACHE	___	___
LAZY EYE	___	___	HIV/AIDS	___	___
DIABETES	___	___	CANCER	___	___
HIGH BLOOD PRESSURE	___	___	SURGERY	___	___
HEARING PROBLEM	___	___	TRAUMA	___	___
NEUROLOGICAL PROBLEM	___	___	OTHER _____	___	___
THYROID PROBLEM	___	___			

ARE YOU CURRENTLY PREGNANT? Yes No ARE YOU CURRENTLY NURSING? Yes No
 DO YOU DRINK ALCOHOL? Yes No Social DO YOU SMOKE? No Yes _____ packs/day
 DO YOU DRIVE A CAR? Yes No ARE YOU ON A SPECIAL DIET? Regular/Low salt/Diabetic
 DO YOU WORK ON A COMPUTER? Yes No IF YES, DO YOU HAVE EYE STRAIN? Yes No

ALLERGIES

PLEASE CIRCLE ANY WHICH APPLY TO YOU:

NONE PENICILLIN CODEINE SULFA OTHER _____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS THAT YOU'RE PRESENTLY TAKING

	NAME OF MEDICINE OR REASON FOR TAKING	STRENGTH	TIMES PER DAY
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		

PARTY RESPONSIBLE FOR FEES/VISION INSURANCE

NAME _____ SS# _____

INSURANCE CO. _____

MEMBER ID NO. _____

I hereby authorize GADDIE EYE CENTERS to furnish information to insurance carriers on my behalf and I hereby assign to the doctor all payment for routine/medical services pertaining to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

I understand that I am responsible for any fees or charges for services and/or materials.

Signature _____ Date _____