WELCOME TO GLENPOOL EYE CARE

Please fill out the information below to help us better serve your eye health needs.

PATIENT INFORMATION

Date_____ Patient Name_____

First Name Middle Name Last Name

Birthday _____ Social Security Number_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race _____ Is English your primary language? ☐ Yes ☐ Other _____

Address _____ City_____ State_____ Zip_____

E-mail _____

Phone Numbers: Home _____ Cell _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

INSURANCE

Insurance Account Holder _____ Relationship_____

Account Holder's SSN_____ Birthday_____

Assignment and Release

I certify that I , and /or my dependent(s), have insurance coverage with _____

Name of Insurance Company

And assign directly to Dr. Gosnell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

Signature of patient, parent, or guardian | Printed name of patient, parent, or guardian | Date

EYE HEALTH HISTORY

Date of last eye exam _____ Optometrist _____

Do you wear glasses? ☐ No ☐ Yes ☐ All the time ☐ Occasionally ☐ Reading ☐ Driving ☐ TV

Are there any tasks you find difficult performing with your glasses? ☐ No ☐ Yes, Explain _____

Do you wear contact lenses? ■ No ☐ Yes

If yes, do you experience end of the day dryness ☐Yes ■No

Do you experience or have you ever been diagnosed with any of the following?

☐ Blurred Vision - Distance	☐ Dry Eyes	☐ Headaches	☐ Migraine Headache
☐ Blurred Vision - Near	☐ Eye Injury	☐ Itching Eyes	☐ Poor Color Vision
☐ Burning Eyes	☐ Eye Strain	☐ Lazy Eye	☐ Poor Night Vision
☐ Cataracts	☐ Floaters	☐ Light Sensitivity	☐ Seeing Flashes
☐ Crossed Eyes	☐ Glaucoma	☐ Loss of Vision	☐ Watery Eyes

EYE HEALTH HISTORY CONTINUED

Do you have family history of any of the following? ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Color Blindness ☐ Retinal Detachment ☐ Blindness

Have you had any eye surgeries? ☐ None ☐ Cataract Surgery ☐ LASIK ☐ Other _____

Are you interested in any of the following?
☐ Prescription Sunwear ☐ Transition Lenses ☐ LASIK ☐ Contact Lenses ☐ Colored Contacts

GENERAL HEALTH HISTORY

Name of Medical Doctor _____ Location of Medical Doctor _____
Pharmacy Name _____ Phone Number_____

Have you or a family member been diagnosed with any of the following?

Condition	Yourself	Family Member	Condition	Yourself	Family Member
AIDS/HIV	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Cancer (Type)_____	☐	☐	Autoimmune Disease (e.g. Lupus)	☐	☐
Chemical Dependency	☐	☐	Seizures	☐	☐
Diabetes (Type_____)	☐	☐	Shingles	☐	☐
Glaucoma	☐	☐	Skin Condition	☐	☐
Heart Condition	☐	☐	Stroke	☐	☐
Hepatitis (Type_____)	☐	☐	Thyroid Condition	☐	☐

Please list any other general health condition not listed above _____

Pregnant? ☐ Yes ▣ No Tobacco Use? ☐ Yes ▣ No
Alcohol Use? ☐ Yes ▣ No Other substance use? ☐ Yes ▣ No

MEDICATIONS	ALLERGIES
List any medications you are currently taking, including eye drops	List any allergies to medications or other substances
_____	_____
_____	_____
_____	_____
_____	_____
☐ No medications ☐ See medication list attached	☐ No Known Drug Allergies