

Welcome to Giron Family Vision Gallery, LLC.

(Please complete front and back of form

Please use Blue or Black ink only)

(SSN is only required when using insurance)

Patient History Form

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone/Cell: _____ Texting Okay? Yes No Gender: Female Male

Email: _____ I was referred by _____

Name of Legal Guardian: _____ S.S.N: _____

Why did you come to see us today?

(Check all that apply)

- I have an eye disease requiring examination
- I want an exam for glasses
- I want an exam for contact lenses
- I am not having any specific eye problems
- I want a diabetic eye examination
- I want a hydroxychloroquine/plaquenil eye examination
- I am having the following problems: _____

I will be using my: Vision Insurance

(Spectera, MES, VSP, Davis, NVA, Avesis,
Starmount/AlwaysCare, Superior)

Cash/Credit

Flex Spending Card

List all medications and supplements you are taking:

List any allergies to medications you have: _____

SOCIAL / ENVIRONMENTAL HISTORY

Employer: _____

Occupation: _____

Marital status: married single other

Are you pregnant? Yes No

Do you smoke? Yes No

Everyday Occasionally Former Never

Do you drink alcohol? Yes ___drinks/day No

Have you had any STD's? Yes No

Have you ever had a blood transfusion? Yes No

Do you have a history of any developmental problems or conditions? Yes No

OCULAR HISTORY

(Do you or a family member have the following?)

Cataracts Self Family

Glaucoma Self Family

Macular Disease Self Family

Dry Eye Self Family

Lasik Self Family

Lazy Eye Self Family

Other _____

Date of last Eye Exam: _____

Please list any Eye Surgeries you have had: _____

What kind of glasses do you wear? General purpose reading bifocal progressive

When do you wear your glasses? Full-time hardly ever only to drive only to read

Do you wear contact lenses? yes no

Please print name of the contacts: _____

Prescription of Contacts: _____

What kind of contacts do you wear? Daily Disposable Toric Bifocal Monovision

How often do you replace your contacts? Daily 2-weeks monthly quarterly yearly

REVIEW OF SYSTEMS – Do you or a family member currently have any of the following?

Diabetes Self Family

(If self, please answer the following questions)

Type 1 or Type 2

Date Diagnosed? _____ Last A1C level? _____ Last blood sugar reading? _____

Blood Pressure Self Family

Arthritis Self Family

Thyroid Condition Self Family

Tumor/Cancer Self Family

Gastro Disease Self Family

Immune Disease Self Family

Bleeding Disorder Self Family

Heart Disease Self Family

Asthma Self Family

Stroke Self Family

Skin Disease Self Family

Psychological Condition Self Family

Neurological Disease Self Family

Blood Disease Self Family

Ear/Nose/Throat Disease Self Family

Kidney Disease Self Family

I give consent for treatment by the doctor of Giron Family Vision Gallery. I understand that payment is due at the time of service. My insurance company will be filed on my behalf by the staff of Giron Family Vision Gallery. I authorize any holder of my medical information to release such information to any agency necessary to determine benefits payable, compliance or utilization. I authorize and direct my insurance carrier(s) to issue payment for services rendered to Giron Family Vision Gallery. Benefits are determined by the contract between you, as the covered member, and your insurance company. I understand that payment for services are ultimately my responsibility and I agree to pay all incurred charges in full immediately upon receipt of a statement from the practice of Giron Family Vision Gallery. I also understand and agree that the practice may amend such terms from time to time and there are NO REFUNDS for any professional services. I further understand that re-examinations after 30 days will be subject to additional exam fees.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms.

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I understand the HIPAA Compliance laws of Giron Family Vision Gallery, and a copy shall be provided at my request.

Patient Signature: _____ **Date:** _____