



GINTER EYECARE CENTER

5713 82nd Street, Lubbock, Texas 79424

(806) 798-8820

www.visionsource-gintereyecare.com

WELCOME

Thank you for selecting our practice for your eye care needs. Please use ink to complete the following information on the front and back of this questionnaire. If you have any questions, do not hesitate to ask for assistance; we will be happy to help you.

TODAY'S DATE: _____ / _____ / _____

Mo Day Yr

PATIENT INFORMATION

Name: _____

Last First Middle

Minor Single Married Widowed

Address: _____

City State Zip

DOB: _____ / _____ / _____ Age: _____ Male / Female

Mo Day Yr

Phone #: (Hm/Wk/Mob) (____) _____ - _____

2nd Ph#: (Hm/Wk/Mob) (____) _____ - _____

If we need to contact you, which # would you prefer us to call? (Hm/Wk/Mob/Please do not contact me)

S.S. Number _____ - _____ - _____

Occupation: _____

Employer: _____

Emergency contact information

Name: _____

Relationship: Spouse/Parent/Other _____

Phone #: (____) _____ - _____

New Patients: Whom may we thank for referring you?

How did you select our office? Yellow pages/ insurance/tv/web site/sign

VISION INSURANCE INFORMATION

Vision Insurance Co: _____

Insurance ID#: _____

Group #: _____

Name of Insured: _____

Relationship: self/spouse/child/other _____

Insured's DOB: _____

Insured's Add: _____

Insured's Ph#: (____) _____ - _____

Insured's Employer: _____

Employer's Ph #: (____) _____ - _____

MEDICAL INSURANCE INFORMATION

Medical Insurance Co: _____

Insurance ID#: _____

Group #: _____

Name of Insured: _____

Relationship self/spouse/child/other _____

Insured's DOB: _____

Insured's Add: _____

Insured's Ph #: (____) _____ - _____

Insured's Employer: _____

Employer's Ph #: (____) _____ - _____

Please present all insurance cards at front desk for a photocopy to be put in your record, which is required by your insurance at each visit

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The questions on front and back of this questionnaire have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor of ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X

SIGNATURE OF PATIENT (or parent if a minor)

DATE

CONFIDENTIAL DOCUMENT

(Please complete both sides)

TO BETTER SERVE YOU WE HAVE AN IN-HOUSE LAB

MOST ORDERS CAN BE DONE THE SAME DAY

GINTER EYECARE CENTER, INC.

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Thank you for taking the time to answer this questionnaire. The information provided will assist your doctor in giving you the best comprehensive eye care available.

What is the reason for today's exam?

- Y N Yearly health exam
- Y N Eye infection
- Y N LASIK/PRK evaluation
- Y N Remove foreign body from eye
- Other: _____

OCULAR/EYE INFORMATION

Do you have any of the following?

- Y N Blurred vision at distance
- Y N Blurred vision at near
- Y N Eye strain with computer use
- Y N Itchy eyes
- Y N Red eyes
- Y N Dry eyes
- Y N Watery eyes
- Y N Eye pain
- Y N Double vision
- Y N Light sensitivity
- Y N Floaters
- Y N Flashes of light

Do you wear or need:

- Y N Glasses
- Y N Contact lenses (circle type)
 - Gas Perm/Hard
 - Soft
 - Bifocal
 - Color/ enhancer
 - Disposable
 - Overnight wear

Have you ever had any of the following? Explain

- Y N Eye infection _____
- Y N Eye injury/surgery _____

Have you ever been told you have any of the following?

- Y N Glaucoma
- Y N High Pressures in your eyes
- Y N Cataracts
- Y N Macular Degeneration
- Y N Retinal holes/tears/degeneration
- Y N Keratoconus
- Y N Blindness
- Y N Any other eye problems not listed: _____

ALLERGY INFORMATION

- Y N Are you **allergic** to any medication(s)
(If yes, list name of medication and reaction)

- Y N Do you have any seasonal/environmental allergies?

WOMEN ONLY

- Y N Are you pregnant/nursing?

DOCTOR USE ONLY

- Reviewed by _____ No changes Date _____
- Reviewed by _____ No changes Date _____
- Reviewed by _____ No changes Date _____

Patient History Information (Confidential)

MEDICAL INFORMATION

Do you have any of the following?

- Y N High Blood Pressure
- Y N Heart disease
- Y N Diabetes (Type I/ Type II)
- Y N High Cholesterol
- Y N Asthma
- Y N Headaches
- Y N Arthritis
- Y N MS
- Y N Lupus
- Y N AIDS
- Y N Cancer
- Y N Other (please describe): _____

Do you have problems with any of these systems?

- Y N Nervous
- Y N Mental
- Y N Respiratory
- Y N Musculoskeletal
- Y N Gastrointestinal
- Y N Genitourinary
- Y N Endocrine/Thyroid
- Y N Blood/Lymph
- Y N Integument (skin)
- Y N Ears/Nose/Throat

MEDICATIONS - List all you currently taking:

(Include aspirin/ vitamins/ hormones/ birth control)

- Y N Have you had any operations/ hospitalizations? Explain

Do you:

- Y N Smoke/Use tobacco?
- Y N Use alcohol?
- Y N Use recreational drugs?

Name of Last Eye Doctor _____

Date of last eye exam _____
Last dilated exam _____

Name of Family Physician _____

Date of last exam _____
Phone number _____
Last Tetanus shot _____

FAMILY HISTORY

Does anyone in your family have any of the following conditions? If yes, **whom?** (Father, Mother, Sibling, Grandparent, Children, etc)

- Y N High blood pressure _____
- Y N Heart disease _____
- Y N Diabetes _____
- Y N Cancer _____
- Y N Glaucoma _____
- Y N Cataracts _____
- Y N Macular degeneration _____
- Y N Retinal problems _____
- Y N Blindness (partial or total) _____
- Y N Other medical/ocular condition not listed _____