Welcome to our Office

It's GREAT to see you! Please fill out the information below! Thank You!

Name:_____ **Today's Date**: ____/____/_____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Phone: (home) _____ (work) _____ (cell) _____

Email Address:_____

Birthdate: _____/_____/_____ **Social Security No.**: _____-_____-_____

Occupation:_____ **Employer**:_____

Employment: FT / PT / Student / Retired/ Other **Marital Status**: Married /Single / Seperated / Divorced / Widowed

Emergency Contact:_____ **Phone**:_____

Race: White / Asian / African American Or Black / American Indian / Hispanic / Pacific Islander

Are YOU Diabetic? Yes / No

Your Height _____ Weight _____lbs. Blood Pressure _____/_____ Blood Sugar _____

Name of Medical Doctor: _____ City:_____

When was your last physical exam? _____

Your EYE History: Please circle any of the conditions that you have experienced:

Macular Degeneration / Blindness / Cataracts / Diabetic Retinopathy / Glaucoma / Lazy Eye /

Retinal Detachment / Visual Field Loss / Other:_____

Your Medical History: Please circle any of the conditions that you have experienced:

ALLERGIES: Seasonal Allergies / Hay fever/ NONE

CARDIOVASCULAR: Heart Murmur / High Blood Pressure/ Stroke / NONE

CONSTITUTIONAL: Coughing / Fatigue / Dizziness / Nosebleeds / NONE

ENDOCRINE: High Cholesterol / Crohn's Disease / **DIABETES** / Gout / Thyroid / NONE

GASTROINTESTINAL: Colon Cancer / Gall Bladder / Acid Reflux / Ulcer / Hepatitis / NONE

GENITOURINARY: Kidney Stones / STD's / Ectopic Pregnancy / NONE

HEAD: Chronic Cough / Dry Mouth / Headaches / Hearing Loss / NONE

HEMATOLOGIC/LYMPHATIC: Anemia / Leukemia / Breast Cancer / Coagulation Disorder / Varicose Vein / NONE

IMMUNOLOGIC: HIV / Lyme Disease / Herpes / Measles / Mumps / Syphilis / NONE

INTEGUMENTARY: Lupus / Skin Disorders (eczema / psoriasis) / NONE

MUSCULOSKELETAL: Arthritis / MS / Osteoporosis / NONE

NEUROLOGICAL: Bell's Palsy / Brain Tumor / Brain Damage / Vertigo / Parkinson's Disease / NONE

PSYCHIATRIC: ADD / Alcoholism / Alzheimer's / Anxiety / Autism / Dementia / Depression / Memory Loss / Schizophrenia / NONE

RESPIRATORY: Asthma / Smoker / Lung Disease / Lung Cancer / Tuberculosis / COPD / NONE

Your Surgeries: Please circle any of the surgeries that you have undergone.

Systemic: Cancer / Biopsy / Cosmetic / Bypass(heart) / Gall Bladder / Other:_____

Eye: Cataract (R / L) / Glaucoma / Lasik / Plugs / PRK / Detachments / Other:_____

Which doctor performed your eye surgery?_____

Any Injuries:_____

Family EYE and Medical History: (Mother, Father, Brother, Sister, Maternal/Paternal Grandparents)

Cataracts: Who?_____ Macular Degeneration: Who?_____

Blindness: Who?_____ Glaucoma: Who?_____

Retinal Detachment: Who?_____ Stroke: Who? _____

Thyroid: Who?_____ Diabetes: Who?_____

Lupus: Who?_____ High Blood Pressure: Who?_____

Heart Disease: Who?_____ Cancer: Who?_____

MEDICATIONS YOU ARE TAKING: Please list medications and for which condition it is taken:

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

Medication Allergy:_____/Reaction:_____

Medication Allergy:_____/Reaction:_____

Medication Allergy:_____/Reaction:_____

Medication Allergy:_____/Reaction:_____

Latex Sensitivity: YES / NO

What medications do you take for your eyes? (Ex: lutein, glaucoma medicine, etc.)

_____ _____ _____

Social History: Please circle all that apply to you.

Do you DRIVE? Yes / No Do you experience any day or night glare issues? Yes / No When:_____

Do you SMOKE or use tobacco products? Yes / No How often? _____

Do you drink ALCOHOL? Never / Socially / Everyday How much?_____

SUBSTANCE Abuse? Never / Socially / Everyday Which substances? _____

What is your BIRTH order? First Child / Middle Child / Youngest Child

Hobbies/Interests: Please circle all that apply to you.

Hunting / Fishing / Snow Skiing / Water Skiing / Reading / Hiking / Bicycling / Motorcycling / Running / Computers / Quilting / Hand Crafts / Boating / Horseback Riding / Woodworking / Mechanical / Metalworking / Basketball / Baseball / Soccer / Golfing / Football / Other: _____

Do you wear GLASSES? All the time / Occasionally / Never

Do you wear CONTACTS? All the time / During waking hours / Occasionally / Never

HIPPA COMPLIANCE: Your information is strictly confidential and will **not be released to anyone without your prior, written consent**, with a possible exception of clinically important letters to your family doctor or co-managing physician or insurance company. I understand that I have the right to refuse to sign this, however, Dr. Griffith's office will not be able to process my insurance and I will be responsible for any charges incurred.

Patient/Guardian's Signature: _____ Date:_____

Doctor's Signature: _____ Date:_____

Are you SELF-PAY or INSURANCE?: In order to submit your insurance, we need a copy of your insurance card or the policy holder's SS#, Date of Birth, and Zip code and a signature. I authorized Dr. Griffith's office to release any information necessary to my insurance agency. I authorize payment of all insurance benefits for services rendered by Dr. Griffith's office to be made to me or on my behalf to Dr. Griffith. I permit a copy of this form to be used in place of the original. I understand that I am responsible for all charges that are not covered by my insurance.

Policy Holder's Social Security #:_____-_____-_____ DOB:_____/_____/_____ Zip:_____

Name of Person Responsible for Payment (if not the patient):_____

Patient/Guardian's Signature:_____ Date:_____

Copy of Insurance Card(s):