WELCOME TO OUR OFFICE!

Please fill out both sides of this form.

PATIENT INFORMATION	RESPONSIBLE PARTY INFORMATION
Title: Mr. / Mrs. / Ms. / Miss / Dr. / Rev. / Father / Sister	Name
Name	Address
Address	City, State, Zip
City, State, Zip	Birthdate
Phone Number	Social Security Number
Work Phone	Employer
Cell Phone	
Email Address	**INSURANCE INFORMATION**
Birthdate	Type of Insurance
Social Security Number	Name of Insured
Employer	Birthdate of Insured
Occupation	*Please provide your card for proper billing*

EYE & MEDICAL HISTORY

Date of Last Eye Exam

Ocular Medications/Drops

Ocular Surgery

Ocular Injuries

Please circle the following choices that pertain to you:

I currently wear glasses Yes No Occasionally Age of Glasses _____

I currently wear contacts Yes No Occasionally No, but I'm interested

Type of contacts Soft Gas Perm Extended Wear

Are they comfortable Yes No Occasionally

How often do you dispose of your contacts? _____

Hours of computer use per day: _____

Do you or any family members have the following conditions?

	Myself	Family Member	Relationship
Blindness	□	□	
Cataract	□	□	
Crossed Eyes	□	□	
Glaucoma	□	□	
Lazy Eye	□	□	
Macular Degeneration	□	□	
Retinal Detachment	□	□	
Retinal Disease	□	□	

Please indicate if you have noticed any of the following:

Dry Eyes	▫	Flashes or Floaters	▫
Itchy Eyes	▫	Double Vision	▫
Tired Eyes	▫	Styes or Chalazions	▫
Headaches	▫	Difficult Night Driving	▫
Glare or Light Sensitivity	▫	Eye Pain or Soreness	▫

Allergies to Medications & Reactions: None or

Current Medications (including over the counter medications, aspirin, oral contraceptives and home remedies)

MEDICAL HISTORY

Last Medical Exam: _____ Medical Doctor: _____

Please list any previous Surgeries and/or Hospitalizations:

Please indicate if you are: ☐ Using Tobacco products ☐ Pregnant ☐ Nursing

Please indicate if you have any problems with the following systems and explain:

Allergy ▫

(Environmental agents, medications, etc)

Cardiovascular ▫

(High blood pressure, high cholesterol, stroke, heart attack, etc)

Constitutional ▫

(Changes in weight, hunger, thirst, sickness, etc)

Cranial/Facial ▫

(Headaches, hearing problems, etc)

Endocrine ▫

(Diabetes, thyroid problems, etc)

Gastrointestinal ▫

(Acid reflux, IBS, etc)

Genitourinary ▫

(Kidney stones, ovarian or prostate problems, etc)

Hematologic/Lymphatic ▫

(Anemia, sickle cell, blood disorders, etc)

Immunologic ▫

(Sarcoidosis, Sjogren's, etc)

Integumentary/Skin ▫

(Psoriasis, dermatitis, rosacea, etc)

Musculoskeletal ☐

(Arthritis, fibromyalgia, osteoporosis, etc)

Neurologic ☐

(Parkinson's disease, MS, seizures, etc)

Psychiatric ☐

(Depression, anxiety, etc)

Respiratory ☐

(Asthma, COPD, emphysema, etc)

NONE of the above ☐

During your examination:

*Do not worry about making a mistake, giving the wrong answer or if you feel your answers contradict themselves

*Do not hesitate to tell the examiner if you are unable to answer their questions

*Do not be alarmed if, for a few minutes during the examination, you feel your vision is getting worse instead of better

Insurance Signature on File

"I certify that information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. Korthals & Associates on my behalf for services and materials furnished. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine those benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my doctor to act as my agent, as above."

Patient Signature Date

Doctor Signature Date