Welcome to Grand Ridge Eye Clinic

Please complete this form and return it to the front desk with **your insurance cards and photo ID.** Thank you!

Reason for visit:_____ **Date:**_____ **Male:** ☐ **Female** ☐

Name:_____ **Date of birth:**_____ **SS#:**_____

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

Home #:_____ **Cell #:**_____ **Email:**_____

How do you prefer to be notified? Phone Call – **Y** ☐ **N** ☐ Text – **Y** ☐ **N** ☐ Email – **Y** ☐ **N** ☐

Bill Payer:_____ **Bill Payer's date of birth:**_____

Employer:_____ **Occupation:**_____

Primary Care Physician:_____ **Date of last eye exam:**_____

Who may we thank for referring you, how did you hear about us?_____

Allergies (medications/environmental):_____

Medications (Including over the counter, drops, etc.)

Custom Lens Questionnaire

Hobbies:_____

How many hours per day do you spend using electronics? (computer/phone/TV, etc.)_____

How many hours per day do you drive? Daytime:_____ Nighttime:_____

List any complaints you have in your current glasses? (fit/function/style/vision)

What do you like most about your current glasses? (fit/function/style/vision)

Rank these in importance 1. Most important, 2. Somewhat important, and 3. Least important:

Fit of frames Select: Fashion Select: Function of glasses Select:

How do you use your glasses? (check all that apply)

☐ **Reading** ☐ **Desk Work** ☐ **Mechanics** ☐ **Digital Devices** ☐ **Crafts** ☐ **Writing** ☐ **Fishing**
☐ **Cooking** ☐ **Shopping** ☐ **TV/Movies** ☐ **Reading music** ☐ **Driving** ☐ **Golfing** ☐ **Biking**
☐ **Traveling** ☐ **Outdoor Activity**_____ **Other**_____

Patient Ocular History

(check all that apply)

☐ **Glaucoma/Glaucoma Suspect** ☐ **Cataract** ☐ **Patching** ☐ **Glasses**
☐ **Strabismus** (crossed eyes) ☐ **Amblyopia** (lazy eye) ☐ **Retinal Degeneration** ☐ **Retinal Hole**
☐ **Age Related Macular Degeneration** ☐ **Retinal Detachment** ☐ **Keratoconus** ☐ **Dry Eye**
☐ **Nystagmus** (involuntary eye movement) ☐ **Inflammatory Disorder** ☐ **Contacts:** _____
☐ **Other:** _____ ☐ **None** ☐ **Eye Injury:** _____

Eye Surgery(s): _____

Family Medical History (check/circle all that apply)

☐ Cancer:	Father	Mother	Bro	Sis	Son	Dau	☐ Diabetes:	Father	Mother	Bro	Sis	Son	Dau
☐ Hypertension:	Father	Mother	Bro	Sis	Son	Dau	☐ Thyroid:	Father	Mother	Bro	Sis	Son	Dau
☐ Other: _____	Father	Mother	Bro	Sis	Son	Dau	☐ None						

Family Ocular History (check/circle all that apply)

☐ Amblyopia (lazy eye):	Father	Mother	Bro	Sis	Son	Dau	☐ Dry Eyes:	Father	Mother	Bro	Sis	Son	Dau
☐ Macular Degeneration:	Father	Mother	Bro	Sis	Son	Dau	☐ Cataract:	Father	Mother	Bro	Sis	Son	Dau
☐ Retinal Detachment:	Father	Mother	Bro	Sis	Son	Dau	☐ Severe Myopia:	Father	Mother	Bro	Sis	Son	Dau
☐ Strabismus:	Father	Mother	Bro	Sis	Son	Dau	☐ Nystagmus:	Father	Mother	Bro	Sis	Son	Dau
☐ Other: _____	Father	Mother	Bro	Sis	Son	Dau	☐ None						

Patient Review of Symptoms (check all that apply & fill in if not listed)

Constitution
- ☐ Developmental Disability
- ☐ Cancer
- ☐ Fatigue
- ☐ Alzheimer
- ☐ Dementia
- ☐ Other

Cardiovascular
- ☐ High blood Pressure
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles
- ☐ Other

Immunological
- ☐ Rheumatoid Arthritis
- ☐ Environmental Allergies
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other

Psychiatric
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Other

Endocrine
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormone Dysfunction
- ☐ Other

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder
- ☐ Other

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Cancer/Disease
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other

Blood/Lymphatic
- ☐ Anemia
- ☐ Lg Volume Blood Loss
- ☐ Ulcer
- ☐ High Cholesterol
- ☐ Other

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other

Other Symptoms:_____

Patient Social History

(check all that apply)

Do you drink alcohol? ☐ Yes ☐ No **Amount/Type:** _____

Do you use tobacco? ☐ Yes ☐ No **Amount/Type:** _____

Smoking Status: ☐ Yes ☐ No (**Current** ☐ **Former** ☐ **Never** ☑)

Release of Information

I authorize the release of my information to the following (contact front desk to add a secondary person):

Name of authorized person: _____Date of Birth_____Relation: _____

Receipt of Notice of Privacy Policy/Late Arrival/No-Show Policies

I, the patient, have read a copy of this office's Notice of Privacy Practices and have been informed of the late arrival and no-show fee policies as well.

Print Patient Name: _____Signature: _____Date:_____

Financial Responsibility

We will be happy to file your insurance claims for you and will do all we can to help you receive the maximum benefits. However, in the event that your insurance determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the insurance.

Print Name: _____Signature:_____Date:_____