NAME ______________________________ Birthdate ____________ (MM/DD/YY)

Name of Family Doctor ____________________ Office phone # or location ____________

## YOUR EYE HISTORY

Check if you have any of the following eye problems:

☐ Blurred vision ☐ Lazy eye ☐ Color defects ☐ Macular degeneration

☐ Eye infection ☐ Crossed eyes ☐ Glaucoma ☐ Cataracts

Other eye problems ______________________________

Please list any previous eye surgery or eye injury ______________________________

Date of your last eye exam ____________ Doctor ____________________

Do you wear contacts? ____________ If no, are you interested in trying contacts? ____________

Are you interested in Laser Refractive Surgery? ______________________________

## REVIEW OF SYSTEMS

Check if you have been diagnosed with any of the following health problems:

☐ Diabetes ☐ Breathing problems ☐ High blood pressure ☐ Anemia

☐ Gastrointestinal ☐ Cancer ☐ Thyroid disorder ☐ Immune disorder

☐ Skin problems ☐ Allergies/sinus ☐ Seizures

☐ Nerve problems ☐ Arthritis ☐ Headaches ☐ NONE OF THESE

☐ Heart trouble ☐ HIV/AIDS ☐ Fatigue

Other health problems ______________________________

For women: Are you pregnant? ☐ Yes ☐ No

Do you get fever blisters or cold sores? ☐ Yes ☐ No (Please note – these can cause eye infections)

Please list past serious injuries or illnesses ______________________________

Please list past major surgeries ______________________________

List all medications you take and why (include eye medications, over-the-counter medicines, and vitamins):

| MEDICINES | REASONS |
|---|---|
| | |
| | |
| | |
| | |

List all medications you are allergic to (such as penicillin, sulfa, novocain, IV dye, etc.):

______________________________

List any environmental allergies (dust, pollen, etc.) or food allergies:

______________________________

## SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No

## FAMILY HISTORY

Check if someone in your immediate family has or has had:

☐ Lazy eye ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Migraines

☐ Diabetes ☐ Arthritis ☐ Strokes ☐ Thyroid disorder ☐ Heart attacks

Other family eye disease ______________________________

*PATIENT SIGNATURE ______________________________ DATE ____________

WELCOME TO OUR OFFICE. At Drs. Grau and Grau our goal is to provide you with professional and caring eye exams. We recommend that everyone have an eye exam every one or two years, starting at age three (especially for those with lazy eye or amblyopia, in the family.)

**Patient Information (Please Print)**

Name_______________________________Birthdate___________________Sex___
Address___________________________City________________State/Zip________
Marital Status________________Social Security #_________________________
Employer_______________________________Occupation____________________

Please provide the following contact numbers. We can now contact patients by texts or e-mails (send reminders, text) but this is voluntary.

Home phone__________Cell_______________Email___________________

Name of Spouse_______________Occupation______________
Spouse'sEmployer________________________________________

Person responsible for payment: Self____Insurance____ Other_____

Emergency Contact______________________________________

Relationship ___________________Phone______________

**If patient is a minor**:Names of parents______________________________________

I give my permission for my child to have any diagnostic eye drops or contact lens service, which are required for an eye exam or contact lens fitting. Parent
Signature____________________________________________

**Insurance Information** Will your visit be covered by insurance?____ If yes, please bring your insurance cards to the receptionist. Insurance might cover medical eye care (infections, injuries) or vision care (exam for glasses or contacts) but not both. We will try to verify your coverage, if possible.

Primary Insurance____________________

Cardholder's Name_________________________

Birthdate____________________

Social Security #____________________________

All insurance co-pays and co-insurance are due at the time service.I authorize the release of any medical information necessary to process my claim. I understand that if my policy requires a referral I must contact my medical doctor before my visit or be responsible for any additional charges. I authorize direct payment of benefits to Drs. Grau and Grau, if they are a provider for my policy, but I understand I am solely responsible for all fees for services, whether or not paid by insurance, at the time they are rendered. I understand there is a federal law requiring issue of Notice of Privacy Practices. I acknowledge I have received a copy, or a copy was made available to me.

Signature__________________________Date_________________________

MEDICAL INSURANCE VS ROUTINE VISION INSURANCE

WHEN YOU ARE BEING SEEN WITH A MEDICAL CONDITION OR BEING DIAGNOSED WITH A MEDICAL CONDTION, YOUR MEDICAL INSURANCE WILL BE FILED.

YOUR ROUTINE VISION COVERAGE IS USED WHEN NO MEDICAL CONDITIONS ARE PRESENT.

BY SIGNING BELOW, I UNDERSTAND THAT THE DECISION IS DETERMINED BY THE DOCTOR AS TO WHICH PLAN WILL BE FILED.

PATIENT SIGNATURE:______________________________ DATE:______________________