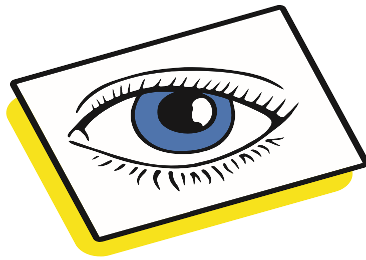

Patient Information **Date____________Dr__________**

First Name______________________________MI______Last Name________________________

Preferred Name__________________Date of Birth_____________SS#________________________

Address_________________________City__________________State_____Zip________________

(Phone) Home_______________________Work____________________Cell___________________

Texting Available Y N Email (if you authorize email correspondence)________________________

Contact Preference email___ work___ home___ cell___

Gender M F Marital Status M S D W

Race_________________Ethnicity_________________Preferred Language____________________

Employer/School____________________________Occupation/Grade__________________________

Hobbies____

Emergency Contact______________________Phone__________________Relationship___________

Names of other family members who are patients in our office_________________________________

Referred by____

Preferred Pharmacy_______________________________

Family Physician (First Name)_______________(Last Name)______________ Phone_____________

Last Eye Exam__________________ Last Eye Doctor________________________

How old are your current glasses?_________ Do you wear contacts Y N Brand_________________

Medical History

Please report any history of problems in the following areas. Y= Yes N= No F= Family

Unexplained weight change Y N
(Cancer) what type__________Y N F
Glaucoma Y N F
Macular Degeneration Y N F
Cataracts Y N F
Allergies/Hay Fever Y N
Sinus congestion Y N
Dizziness Y N F
Heart pain Y N F
High blood pressure Y N F
Stroke Y N F
Heart attack Y N F
High Cholesterol Y N F
Asthma Y N F
Chronic Bronchitis Y N F
Emphysema Y N F

Any genitourinary Y N F
Rheumatoid arthritis Y N F
Fibromyalgia Y N F
Osteoarthritis Y N F
Muscular Dystrophy Y N F
Headaches Y N F
Migraines Y N F
Seizures Y N F
Depression/Anxiety Y N F
Thyroid Disorders Y N F
Diabetes Y N F
Anemia Y N F
Bleeding problems Y N F
Aids/HIV + Y N
Any gastrointestinal Y N F
Double Vision Y N

Are you pregnant? Y N Due date____________ Do you smoke? Y N How much________________

Have you had eye surgery? Y N What kind________________________When__________________

Drug Allergies____

Current Medications (strength and how often it's taken):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

CONTACT RELEASE INFORMATION

I agree to permit Drs. Todd & Giannetti EyeCare, PA and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account. Patient/Customer/Guardian Signature: ____

ONE TIME AUTHORIZATION (MEDICARE)

Approved Form No: OMB No. 0938-0222

I request that payment of authorized **Medicare** Benefits be made either to me or on my behalf to Dr. Mike Todd, Dr. Jace Giannetti, and Dr. Ashley Ralston for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: ____ Date Signed: _________________

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Form 514 (01/12)

ONE TIME AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Drs. Todd & Giannetti EyeCare, PA for any services furnished to me. I authorize release of any medical information concerning me to your company and its agents any information needed to determine these benefits or benefits payable for related services. I also agree to pay this bill in full for any uncovered services by my insurance company. Initial_______

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practice and a copy of my rights regarding electronic health information exchange, for the office of Drs. Todd & Giannetti EyeCare, PA. Initial______

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please be advised that we cannot speak with anyone that is not listed on this form. This includes spouses, children, and caregivers.)

I am authorizing the personnel at Drs. Todd & Giannetti EyeCare, PA to leave medical information and test results with others if I am not available.

_______ I do not wish to have any information released to anyone besides myself.

OR I authorize that my information can be left with:

□ Emergency contact (listed on front pg.) □ Spouse________________________ □ Son______________________

□ Daughter____________________________ □ Other______________________________

Patient/Guardian Signature:____ Date Signed:_____________

Patient/Guardian Name (Printed):____