

The Grafton Eye Center



(Please print clearly the answers to all questions. Your information will remain confidential per HIPAA policy)

Name: _____ Date: _____

First

Middle

Last

Street Address: _____ Apt # _____ City _____ State _____ Zip _____

Phone Number to Best Reach You:(_____) _____ Date of Birth: _____

Email Address(used for confirming appointments/orders/doctor communication only): _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Hobbies/Sports: _____

Occupation (or Grade): _____ Employer (or School): _____

If minor, PARENT/GUARDIAN name: _____

Who is your Medical Health Insurance Carrier if any? _____

Who is your Vision Insurance Carrier if any? _____

The name of your Medical Doctor is: _____

How did you hear about our office? _____

Personal Eye History

Do you have any of the following eye problems? Blurred vision Irritation/Infection Pain/Soreness Strain Glare/Halos
 Floaters/Flashers in vision Dryness Redness Itchy Watery Light Sensitivity Headaches Other: _____

When was your last eye exam? (Approximately) _____ Doctors Name/ Location: _____

Do you wear GLASSES? Yes No If YES, do you have them with you TODAY? Yes No

When do you wear your GLASSES? Full time Part time Reading Distance/ Driving Computer Use Safety

Describe your Computer use: Extensive (5+ hrs/day) Moderate (1-4 hrs/day) Low (1hr/day or less) Seldom Never

Had any Eye surgery: None Lasik RK Cataract Retina Glaucoma Eyelid Other _____

Are you interested in wearing CONTACTS? Yes Maybe No Currently Wear Contacts

Are you interested in LASIK information or other corrective surgery for your vision? Yes Maybe No

THE FOLLOWING QUESTIONS ARE FOR CURRENT CONTACT LENS WEARERS ONLY

Lens Type: Soft Disposable Soft Yearly Colored RGP (Hard)
 Monovision Bifocal/Multifocal For Astigmatism

If you know the Brand and Power of your contacts, please indicate: _____

How often do you sleep overnight with your CONTACTS? _____

How often do you replace your lenses with new lenses? _____

How old are the contacts you are currently wearing? _____

How many hours are you able to wear your CONTACTS before they begin to irritate you or feel dry? _____

Any other problems/issues/concerns with your current contacts? _____

Personal Medical History (Many general medical/health conditions affect the eye and your vision)

Do you take any prescription or non-prescription medicines regularly? Yes No If yes, please list all known medicines: _____

Do you have any medication allergies: None known Penicillin Sulfa drugs Other: _____

Do you have problems with the following medical systems? Please check this box if you **Do Not** have any medical conditions.

<u>Constitutional</u> <input type="checkbox"/> None <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Fever <input type="checkbox"/> Cancer <input type="checkbox"/> Other _____	<u>Neurological</u> <input type="checkbox"/> None <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other _____	<u>Gastrointestinal</u> <input type="checkbox"/> None <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Digestive concern <input type="checkbox"/> Other _____
<u>Allergic/Immunologic</u> <input type="checkbox"/> None <input type="checkbox"/> Drug allergy <input type="checkbox"/> Environmental Allergy <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Other _____	<u>Endocrine</u> <input type="checkbox"/> None <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Hormonal Dysfunction	<u>Musculoskeletal</u> <input type="checkbox"/> None <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other _____
<u>Cardiovascular</u> <input type="checkbox"/> None <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular disease <input type="checkbox"/> High Blood Pressure/HTN <input type="checkbox"/> High cholesterol	<u>Blood/Lymphatic</u> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other _____	<u>Integumentary / Skin</u> <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other _____
<u>Genitourinary</u> <input type="checkbox"/> None <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney concerns <input type="checkbox"/> STD: Herpes, Chlamydia, HIV	<u>Psychiatric</u> <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other _____	<u>Respiratory</u> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Other _____
<u>Ears, Nose & Throat</u> <input type="checkbox"/> None <input type="checkbox"/> Upper respiratory tract infection <input type="checkbox"/> Other _____	<u>Anything Not Listed:</u> _____	

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

- | | | |
|---|--|-------|
| <input type="checkbox"/> None | <input type="checkbox"/> Corneal disease | _____ |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Lazy Eye | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Hereditary Disease | _____ |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other Eye Disorders | _____ |

Social History

Use Tobacco Currently? Yes No Use Tobacco Significantly in Past? Yes No Drink Alcohol? Yes No

Are you pregnant? Yes No Breast feeding? Yes No

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Kristopher Knous O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Kristopher Knous O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signature _____

Date _____

Acknowledgment of Privacy/HIPPA and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form. Copies are available for your personal documents if desired.

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient

Print Name