# 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?_____**

**CONTINUED ON BACK**

# 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.

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

# Family Medical History

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

- ❑ None
- ❑ Blindness _____
- ❑ Cataracts _____
- ❑ Glaucoma _____
- ❑ Macular Degeneration_____
- ❑ Retinal Detachment _____
- ❑ Corneal disease _____
- ❑ Lazy Eye _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Hereditary Disease _____
- ❑ Other Eye Disorders _____

# Social History

**Use Tobacco Currently?** ❑Yes ❑No **Use Tobacco Signifcantly 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**

_____ _____

Reviewed by Dr:_____ Date:_____