AMERICAN | EYECARE

See. Life. Better.

Stacey Carabello, O.D. | Tod Gerhardt, O.D. | Abby Granera, O.D. | Logan Granera, O.D. | Matthew Ruhl, O.D.

Date:____________________________

Patient Name:____ Phone:_______________________________
First Middle Last

Address:______________________________City:____________State:________Zip:___________Email:__________________________

SSN:_____________________________ ☐ Male ☐ Female Birthdate:___________________

Check the appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parents employer:____Work Phone:_______________________

Business Address:_______________________________________City/State:_____________________________

Person to contact in case of emergency:_______________________________________Phone:_____________________

Responsible Party

Name of person responsible for this account:______________________________Relationship to the patient:_________________

Address:____Home Phone:_____________________________

Birthdate:______________________________Financial institution:_______________________________________

Employer:____Work Phone:________________

Is this person currently a patient of our office? ☐ Yes ☐ No

HIPPA Authorization & Release of Medical Information

I authorize release of any information concerning myself, or my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, be made directly to the doctor(s) today and in the future.

I acknowledge that I was offered/received a copy of American Eyecare's Notice of Privacy Practices. (If patient is under guardianship, legal guardian should sign as well).

____

Signature of patient or parent/guardian if a minor. Date.

Authorized to Access Medical Records	Initial

If we can do anything special for you
Please ask!

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Medical Information

Personal/Social History

Occupation:____________________ Visual demands? ☐ Distance ☐ Reading ☐ Computer ☐ Welding ☐ Power tools ☐ High speed objects?

Are you pregnant or nursing? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes______pkg/day Alcohol consumption____/day ☐ social only

Have you ever been infected with a communicable disease ☐ No ☐ Yes Explain:____

Review of Organ Systems: (Please circle all systems that you have been diagnosed with and list the specific condition in **Present Illness** and your medications)

No known medical conditions

Thyroid/Hormone/Glands Neurological Lymphatic/Hematological Ears/Nose/Mouth/Throat Collagen-vascular disorders Respiratory

Stomach/Intestine/Colon Bone/Joint/Muscle Genital/Bladder/Kidney Psychiatric Skin diseases/disorders Eye health conditions

Family Medical Doctor:____________________**Pharmacy:**______________________**Medication Allergies:**______________________

Current Medications:	Dosages	**Present Illness:** (chronic & acute)	Date diagnosed

Family History (Please list your blood relatives that have been diagnosed with the following:)

Blindness:____________________________________ Diabetes:____________________________

Cataract:____________________________________ Heart Disease:____________________________

Crossed eyes:____________________________________ High blood pressure:____________________________

Glaucoma:____________________________________ Kidney disease:____________________________

Macular degeneration:____________________________________ Lupus:____________________________

Retinal detachment:____________________________________ Thyroid disease:____________________________

Cancer:____________________________________ Other:____________________________