Griebenow Eyecare Patient Information Form

Print Form

Welcome to Griebenow Eyecare! For faster service, please complete this form prior to your appointment. Please print or type in this form.

Patient Information

First Name: _____ MI: ____ Last Name: _____ Today's Date: _____

Preferred Name (i.e. Bob vs. Robert): _____ Date of Birth (MM/DD/YY): _____

Parent or Guardian (If Applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-mail: _____

How did you learn about our office? _____

Primary Care Physician: _____

Occupation & Employer: _____

School Attending & Grade Level (If Applicable): _____

How do you prefer we contact you? ☐ Home Phone ☐ E-mail ☐ Mobile Phone ☐ Text Message ☐ Work Phone ☐ U.S. Mail

In case of emergency, contact: _____

Relationship: _____ Emergency Phone: _____

Gender:
☐ Male ☐ Female

Race/Ethnicity:
☐ White (Not Hispanic)
☐ Hispanic/Latino
☐ African American/Black
☐ Asian
☐ American Indian/Eskimo
Other (Specify): _____
☐ *Prefer not to answer*

Marital Status:
☐ Single ☐ Married
☐ Other: _____

Current Corrective Lenses:
☐ Glasses ☐ Contacts
☐ None

Primary Insurance

Medical Insurance Company: _____ Vision Insurance Company: _____

Subscriber Name: _____

Gender:
☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

SSN _____ Subscriber Date of Birth (MM/DD/YY): _____

Employer: _____

Secondary Insurance

If you have a secondary health insurance provider, please list the insurance company and policy number here:

☐ *By checking this box, I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges, regardless of insurance benefits. Payment is due at the time services are rendered.*

☐ *By checking this box, I acknowledge that I have received a copy of Griebenow Eyecare's Notice of Privacy Practices (HIPAA Compliance).*

Patient or Parent/Guardian Signature: _____ Today's Date: _____

Please turn over form and enter health history information. ------>

Health History

Please provide us with your health information by checking all of the boxes that currently apply.

Allergic/Immunologic

- ☐ Drug allergy
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ **None**

Eyes

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ Blurred vision
- ☐ **None**

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing spondylitis
- ☐ **None**

Cardiovascular

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Vascular disease
- ☐ **None**

Gastrointestinal

- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ **None**

Neurological

- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Cerebrovascular
- ☐ **None**

Constitutional

- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ **None**

Genitourinary

- ☐ STD, Herpes, Chlamydia
- ☐ **None**

Psychiatric

- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ **None**

Ear, Nose, Mouth & Throat

- ☐ Respiratory Tract Infection
- ☐ Ear ache
- ☐ Runny nose
- ☐ Sore throat
- ☐ **None**

Blood/Lymphatic

- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Leukemia
- ☐ **None**

Respiratory

- ☐ Current smoker
- ☐ Previous smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ **None**

Endocrine

- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Thyroid disorder
- ☐ Hormonal disorder
- ☐ **None**

Skin

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ **None**

Please list any other health issues/conditions that are not listed above.

Patient Allergies & Medications

Allergies (list all allergies, including allergies to environments and/or medications):

Current medications (list both prescription and over-the-counter medications):
If no medications taken, please write, "none" in box below.

Family Health History

Please check if there is any family history of any of the following:

- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Lazy Eye
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke