

Date _____

Welcome to Gailmard Eye Center

Patient's name (minor, age 18 or younger) _____

Parent's names _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Who referred you to our office? (Name) _____

Insurance listing Family member Yellow pages Physician / Eye Doctor

Patient's date of birth _____ Grade in school _____

Name of parent responsible for account _____

Parent's Occupation _____ Parent's social security number _____

Name of employer _____ City _____

Please list any members of your household who come to our office _____

Please list any eye problems, medical problems or learning / developmental problems the patient has:

Who is the patient's family physician? _____

Have any blood line relatives had glaucoma, or other loss of sight? _____

Is patient allergic to any medications? Yes No (List) _____

Does patient presently wear glasses? Yes No How old are the glasses? _____

When does he/she wear them? _____

Does patient presently wear contact lenses? Yes No Hard Gas Permeable Soft Disposable

If yes, how old are the contacts? _____ If no, has patient ever worn contacts? Yes No

Previous eye doctor _____

Does patient have vision care insurance? Yes No Name and ID # _____

Do you have health insurance? Yes No Name and ID number _____

Please note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist.