Patient Welcome Form

Patient Information

First Name_____ Patient Date of Birth_____

Last Name_____ Patient Social Security _____

Street Address_____ Gender_____ Race_____ Ethnicity_____

_____ Occupation _____

City/State/ZIP_____ **Guardian Information (if patient is under 18 years of age)**

Daytime Phone_____ First Name _____

Cell Phone_____ Last Name _____

Email_____ Relationship to Patient_____

Preferred Contact Method: Cell___Email___Home ___ Is Guardian Current Patient (Y / N)

How did you select our office: Friend/Relative __Doctor__Website__ Insurance__Social Media__Other_____

Insurance Information

Vision Insurance _____

Vision Insurance Member Name _____

Vision Insurance Member ID# _____

Vision Insurance Member D.O.B _____Relationship to Patient _____

Primary Medical Insurance_____

Primary Member Name _____

Primary Member Social Security _____

Policy/ I.D. # _____

Group Number_____

Please list any secondary vision or medical insurance information below:_____

_____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- ☐ Yes, I have read or had explained to me GNO Eyecare's statement of privacy practices. I wish to continue my care under said terms.
- ☐ No, I have not read the privacy practice and I choose not to read them. I wish to continue my care under said terms.

By signing below I am declaring that all information provided is correct to the best of my knowledge. I understand that if insurance information is not given on the date of the exam, I will not be able to show proof of insurance at a later date to gain benefits. I acknowledge the financial agreement and understand that payment is due on the date that services are rendered. I also acknowledge there will be a $25 fee for NSF and bounced check.

Signature_____ Date_____

Ocular / Eye History

Have you or a family member experienced or been treated for any of the following? Circle all that apply.

Cataracts	yes	no	family_____
Crossed / Lazy Eye	yes	no	family_____
Dry Eye	yes	no	family_____
Glaucoma	yes	no	family_____
LASIK / PRK	yes	no	family_____
Macular Degeneration	yes	no	family_____
Retinal Detachment	yes	no	family_____

Other Eye Conditions or Surgery:

Patient Eye History

Date of Last Eye Exam_____ Location_____

Currently Wearing Glasses?_____Type_____

Currently Wearing Contacts?_____ Type_____

Reason for Visit?_____

_____

Medical History

Have you or a family member experienced or been treated for any of the following? Circle all that apply.

Allergies	yes	no	family_____
Cancer	yes	no	family_____
Diabetes	yes	no	family_____
Heart Disease	yes	no	family_____
Hypertension	yes	no	family_____
High Cholesterol	yes	no	family_____
Stroke	yes	no	family_____
Thyroid Condition	yes	no	family_____

Other:_____

Primary Doctor/Pediatrician_____

Current Medications:_____

_____

Medication Allergies:_____

Are you experiencing or have experienced any of the following? Please circle all that apply:

Blurred Vision Burning Discharge Double Vision Dryness Eye Pain Floaters/Flashes Headaches Itching Redness Eye Fatigue Problems with Glare Problems with Night Vision

Would you be interested in our staff or doctors discussing with you any of the following? Circle all that apply:

Backup Glasses Contact Lenses Color Contact Lenses LASIK Sunglasses Sport glasses Shooting Glasses Safety Glasses

At GNO Eyecare, we recommend a dilation annually for all our patients. Drops are used to open the view of the eye so our doctors can carefully examine you for any eye disease. The dilation may last for 2-3 hours after the exam and can make your eyes light sensitive and blur your vision. Driving is generally possible but use caution. All new patients should expect to have their eyes dilated.

Our office is proud to provide you with the most state of the art equipment to assess early eye disease and potentially vision threatening conditions. We offer the testing below on the same day of the exam.

Visual Field Test

The Visual Field Test measures the retinal function and sensitivity to light. It is a method of measuring an individual's entire scope of vision, that is their central and peripheral (side) vision. The visual field test is a subjective examination and can assist in important early detections of many disorders such as: **Glaucoma, Diabetes, Retinal Detachment, Brain Tumors, Aneurysms.** Our Doctors strongly recommend this quick, yet accurate exam for all patients, especially those who have any of the following: **Headaches, Flashes of Light or Floaters, Family Hx of Diabetes or High Blood Pressure, Over the age of 35, Heart Problems High Glasses Prescriptions, or Unexplained vision changes.**

- ☐ I would like more information
- ☐ I would like to skip all imaging