Michael B Gordon, OD

Patient Medical Information

Name: ______________________ Preferred Name: ______________________ Date: __________

Street Address or P.O. Box: ______________________ Home#: __________

City, State & Zip: ______________________ Cell#: __________

Date of Birth: ______________________ Work#: __________

Email Address: ______________________ **Preferred Contact Method**: ❑ Email ❑Home ❑ Cell ❑Work

Employer/School: ______________________ Occupation/Grade: __________

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Spouse/Partner: ______________________

Other **family members** living at home (please list names & ages): ______________________

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Emergency contact/ Authorization to speak on your behalf (i.e., parent, spouse, child, etc.)?

Name: ______________________ Relation to you: __________ Phone#: __________

Primary Medical Doctor: ______________________ Last Physical: __________

How did you find out about our office? ❑ Doctor __________ ❑ Insurance ❑ Previous Patient

❑ Location ❑ Internet search ❑ Phonebook ❑ Website ❑ Friend/co-worker __________

Primary Health Insurance Carrier: ______________________ ID #: __________

Who is the **employer** of the subscriber? ______________________ Relation to Subscriber: ❑ Self ❑ Spouse ❑ Child

Secondary Health Insurance Carrier: ______________________ ID #: __________

Person Responsible for Billing: ______________________ Do you have a Vision Plan? ❑ Yes ❑ No

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Please complete the following information as requested in the **Health Care Reform Requirements:**

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander

Preferred Language: __________ **Height:** __________ **Weight:** __________ **Blood Pressure**: _____/_____

Which **hobbies or sports** do you enjoy? ______________________

On average, how many **hours per day** do you use any **electronic devices** (i.e. tablet, smart phone, computer etc.)? __________

Do you wear **contacts**? ❑ YES ❑ NO If yes, do you sleep with them? ❑ YES ❑ NO

Do you have any history of any eye i**njury, surgery**, or **eye disease/condition**? ❑ YES ❑ NO

If yes, please explain: ______________________

Medications Are you currently taking any medications? ❑ Yes ❑ No

If yes, **please list all medications/vitamins/supplements/homeopathic remedies &reason:**_______________

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Medical History
Do you currently have, or have ever had, any of the following conditions?

Eyes
- ❑ glaucoma
- ❑ cataracts
- ❑ age-related macular degeneration
- ❑ itching
- ❑ sandy, gritty, dry eyes or excessive tearing
- ❑ flashes of light
- ❑ floaters
- ❑ double vision
- ❑ blurred or sudden loss of vision
- ❑ sensitivity to light

Allergic/Immunologic
- ❑ drug allergies __________
- ❑ environmental allergies
- ❑ lupus
- ❑ RA
- ❑ other__________

Musculoskeletal
- ❑ arthritis
- ❑ muscular dystrophy
- ❑ fibromyalgia
- ❑ other__________

Cardiovascular
- ❑ heart disease
- ❑ high blood pressure
- ❑ stroke
- ❑ elevated cholesterol
- ❑ other__________

Gastrointestinal
- ❑ Colitis
- ❑ ulcer
- ❑ other__________

Neurological
- ❑ MS
- ❑ epilepsy
- ❑ Alzheimer's
- ❑ Parkinson's
- ❑ other__________

Constitutional
- ❑ sudden weight loss/gain
- ❑ developmental disability
- ❑ fatigue
- ❑ other__________

Genitourinary
- ❑ kidney disease
- ❑ other __________

Psychiatric
- ❑ depression
- ❑ panic disorder
- ❑ schizophrenia
- ❑ other__________

Ear, Nose, Mouth & Throat
- ❑ upper respiratory infection
- ❑ ringing/tinnitus
- ❑ other__________

Hematologic/Lymphatic
- ❑ anemia
- ❑ leukemia
- ❑ other__________

Respiratory
- ❑ asthma
- ❑ emphysema/COPD
- ❑ other__________

Do you currently smoke? ❑ YES ❑ NO
Are you a previous smoker? ❑ YES ❑ NO

Endocrine
- ❑ insulin-dependent diabetes
- ❑ non-insulin dependent diabetes
- ❑ thyroid disorder
- ❑ other__________

Integumentary
- ❑ eczema
- ❑ psoriasis
- ❑ rosacea
- ❑ other__________

Please list **any condition that may not be listed above** & explain: _______________

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Family History
Please check any of the following conditions that any **blood-related family member** has had & which relative:

- ❑ glaucoma__________
- ❑ macular degeneration__________
- ❑ cataracts__________
- ❑ retinal detachments __________
- ❑ high blood pressure__________
- ❑ diabetes__________
- ❑ stroke__________
- ❑ blindness__________

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OUR OFFICE POLICIES

Welcome to our office. The goal of our office is to provide quality eye care to all of our patients. In order to serve you better, please read the following office policies and then sign below:

- All professional fees are due at the time services are rendered. This includes any applicable insurance co-pays.
- Please present any and all insurance information at the time of visit.
- Payment of all professional services and supplies are ultimately the patient's responsibility. If you do not have your insurance information at the time of your visit, we will be happy to provide you with the appropriate receipts for you to obtain direct reimbursement yourself. We recommend that you call your individual insurance company for your particular benefits and coverage information.
- A 50% deposit is required to order eyeglasses and/or contact lenses. The remaining balance is due at the time of pick up.

Please be advised that our office requires a **48 hour notice** for canceling or rescheduling appointments. A fee may be incurred if the proper notice is not given.

Most importantly, please let us know if you have any questions or concerns. Thank you for choosing our office for all your eye care needs.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Michael B. Gordon, OD's Notice of Privacy Practices.

Patient Name ______________________________

Signature ________________________ Date __________