

Michael B. Gordon, OD



Patient Medical Information

Name: _____ Preferred Name: _____ Date: _____

Gender: Male Female Other _____ Personal Pronouns: _____

Date of Birth: _____ Work#: _____

Street Address or P.O. Box: _____ Home#: _____

City, State & Zip: _____ Cell#: _____

Email Address: _____ Preferred Contact Method: Email Home Cell Work

Employer/Occupation: _____ School/Grade Level: _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Spouse/Partner: _____

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

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 _____ Location Internet search/Website

Insurance Seen by Dr. Gordon before 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

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 have any history of any eye **injury, surgery, or eye disease/condition?** YES NO

If yes, please explain: _____

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

Medications Are you currently taking any medications? Yes No

If yes, please list all medications/vitamins/supplements/homeopathic remedies &: _____

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: _____

Family History

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

- | | |
|---|--|
| <input type="checkbox"/> glaucoma _____ | <input type="checkbox"/> high blood pressure _____ |
| <input type="checkbox"/> macular degeneration _____ | <input type="checkbox"/> diabetes _____ |
| <input type="checkbox"/> cataracts _____ | <input type="checkbox"/> stroke _____ |
| <input type="checkbox"/> retinal detachments _____ | <input type="checkbox"/> blindness _____ |

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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-payments.
- Please present any and all insurance information at the time of your 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. It is ultimately the patient's responsibility to know their insurance policy.
- 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 _____