

GilesEyeCare
Patient Information

Patient name _____ Date of Birth _____ Sex _____
Address (Street) _____
(City) _____ (State) _____ (Zip) _____
Homephone _____ Workphone _____ Cellphone _____
E-mail _____
SS# _____ Parents name (If < 18y.o.) _____
Marital status (for insurance) _____ Spouse if married _____
Occupation _____ [] Employed [] Full time student [] Part time student
Person to notify in case of emergency _____
Primary Physician _____ Referred by _____

History

Any serious eye problems or eye surgery in the past? [] Yes [] No

If yes please explain: _____

Other previous illnesses (with approximate dates)

Please list medications which you currently take

Allergies to any medications? [] Yes _____ [] No

Please check if applicable

Family history of glaucoma? [] Family history of macular degeneration? []
Family history of cataracts? [] Family history of heart disease? [] Stroke? []
Family history of high cholesterol? [] Family history of diabetes? []

Please put a check mark only to those that apply to you.

[] High blood pressure	[] Asthma	[] Weight gain or loss	
[] Elevated cholesterol	[] Emphysema	[] Unexplained fatigue	
[] Heart disease	[] Bronchitis	[] Anemia or swollen glands	
[] Heart attack	[] Shortness of breath	[] Weakness/injury(extremity)	
[] Irregular heart beat	[] Frequent cough	[] Psychiatric illness	
[] Congestive heart failure	[] Nose/throat problems	[] Depression	
[] Stroke	[] Hepatitis	[] Alzheimer's	[] Anxiety
[] Chest Pain (angina)	[] HIV/Aids	[] Parkinson's D.	[] M.S.
[] Diabetes	[] Herpes	[] Muscular D.	[] Ulcer
[] Frequent heartburn	[] Unexplained fever	[] Tremors	[] Colitis
[] Migraine/headache	[] Kidney disease	[] Skin disorder	[] Hay fever
[] Arthritis	[] Thyroid disease	[] Eczema/hives	[] Sinusitis
[] Cancer	[] Enlarged prostate	[] Hard of hearing	[] TB
[] Other _____			
[] Alcohol use/ per week _____		[] Smoking/packs/day _____	

Patient signature: _____ **Date:** _____

Reviewed by: Tracy K. Giles, O.D. _____

Health Insurance Information

Patients Name _____

Date _____

Primary insurance _____ **Effective date** _____

Certification/ ID # _____ Group # _____

Address _____

Secondary insurance _____ **Effective date** _____

Certification/ ID# _____ Group # _____

Address _____

**If subscriber is someone other than the patient, please complete this section.
Insurance forms require this information!**

Subscribers Name: _____

Patient's relationship to Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SS#: _____

Subscriber address if different: _____

Please bring your insurance card with you

I certify that the information given by me in applying for insurance payment is true and correct. I authorize Dr. Giles to act as my agent in helping me obtain payment for covered services/products. I authorize payment of these benefits directly to Dr. Giles on my behalf for any services/products furnished. I realize that if prior authorization for my office visit is necessary and I do not obtain one, my insurer may deny payment and that I am responsible for payment. I also understand that if I have already paid for a service/product and later discover that I have coverage for same serves/products, I must seek self-reimbursement from my insurer. Credits will no longer be issued in these cases. We appreciate your understanding and cooperation.

Signature _____

Date _____

