Welcome to the office of Dr. Gary Wolf

Please provide us with the following **Patient Information.** All information is strictly confidential.

Today's Date:____/_____/_____ Patient Name: Last_____First_____MI_____

Date of Birth:_____/_____/_____ SS# :_____ ☐Miss ☐Mrs ☐Ms ☐Master ☐Mr. ☐Dr ☐Fr

Address:_____City:_____State:_____ZIP:_____

Patient's Employer:_____Occupation:_____Home Phone:( )_____

Work Phone: ( )_____ Cell Phone: ( )_____ Email: _____

If this is **your first** exam here, please tell us **HOW YOU HEARD** of our office? _____

Person to contact in case of emergency: _____ Phone:( )_____

Medical Insurance:_____Subscriber Name_____ID# _____DOB__/__/__

Vision Insurance:_____Subscriber Name_____ ID # _____DOB__/__/__

Responsible Party

Name of **person responsible for account:** _____DOB__/__/__

Relationship to patient:_____ Home Phone: ( )_____Work Phone:( )_____

Address:_____City:_____State:_____ZIP_____

Is the responsible person currently a patient at this office?: ☐ Yes ☐ No

In the case of divorced parents, the person bringing the child for services will be considered the responsible party.

Assignment and Release

I authorize payment of benefits directly to Dr. Gary Wolf for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require pre-approval from my primary care physician, and that if I do not obtain such approval, I am financially liable for the services.

I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles and fees not paid by my insurance carrier, as well as collections and returned check fees will be my responsibility.

I also acknowledge that I received a copy of Dr. Gary Wolf's " NOTICE OF PRIVACY ACT, HIPPA" policy.

_____ _____

Signature of patient or parent/guardian if a minor **Date**

Medical History Questionnaire

When I wear my glasses (or contacts), I have trouble with my **FAR** vision ☐ Yes ☐ No

When I wear my glasses (or contacts), I have trouble with my **NEAR** vision when reading ☐ Yes ☐ No

I do not wear glasses or contacts for **distance** and **I do** have trouble with my **FAR** vision ☐ Yes ☐ No

I do not wear glasses for **NEAR** use and **I do** have trouble with my **NEAR** vision for reading ☐ Yes ☐ No

What NEW PROBLEMS are you having SINCE YOUR LAST EYE EXAM? Check all that apply; IF NONE APPLY, check this box ☐

☐ Halos around lights ☐ Burning ☐ Sandy or gritty feeling ☐ Watering Excessively
☐ Double vision ☐ Redness ☐ Mucous discharge ☐ Eye pain or soreness
☐ Flashing lights ☐ Itching ☐ Glare/light sensitive ☐ Crusting on eyelashes
☐ Loss of peripheral vision ☐ Dryness ☐ Floating spots ☐ Tired Eyes

Do you have any of the following eye conditions? Check all that apply:

☐ Cataracts ☐ Diabetic eye disease ☐ Macular degeneration
☐ Glaucoma ☐ Retinal detachment/retinal disease ☐ Lazy eye (amblyopia)

Other visual problems not listed above:_____

Was your last eye exam with Dr. Wolf? ☐ Yes ☐ No

If not, who was the eye doctor and when was your last eye exam? Dr. _____Date_____/_____/_____

Do you wear prescription eyeglasses? ☐ Yes ☐ No Bifocals or no-line progressives ☐ Yes ☐ No

Do you wear contact lenses? ☐ **Yes** ☐ **No** **Do you wish to be fitted with contact lenses?** ☐ **Yes** ☐ **No**

**>>>>>>>>>>>>>>>>>>>>>>>>>>*SIDE ONE, PLEASE TURN PAGE OVER* >>>>>>>>>>>>>>>>>>>>

Review of Systems

Do you have any of the following medical conditions? Check all that apply:

- ☐ Headaches
- ☐ Diabetes
- ☐ Chronic bronchitis
- ☐ High blood pressure
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Depression
- ☐ Allergies/hay fever
- ☐ Migraine
- ☐ Bleeding disorder
- ☐ Stroke/seizure
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Asthma
- ☐ Sinus congestion
- ☐ Emphysema
- ☐ High cholesterol
- ☐ Psoriasis or rosacae
- ☐ Heart disease
- ☐ Heart/chest pain

Other:_____

Please **list all medications** you are currently taking, or give us your list to photocopy_____

_____

_____

_____

Are you allergic to any medications? ☐Yes ☐No If yes, please list:_____

_____

When was your last physical exam?: ____/____/____ Who is your primary care physician? _____

Females: Are you pregnant or nursing? ☐**Yes** ☐ **No** Location of Primary Care Dr.'s Office_____

Family Medical/Ocular History:

Do any blood relatives have any of the following eye or medical conditions?

PLEASE CHECK ALL THAT APPLY AND *INDICATE THEIR RELATIONSHIP TO YOU:*

- ☐ Blindness_____
- ☐ Cataracts_____
- ☐ Diabetes _____
- ☐ Thyroid disease_____
- ☐ Glaucoma_____
- ☐ Macular degeneration_____
- ☐ High blood pressure_____
- ☐ Retinal disease/ or retinal detachment _____
- ☐ Diabetic eye disease_____
- ☐ Lazy eye _____
- ☐ Cancer _____

Other:_____

Social History:

Please answer the following:

Do you drive? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

Are you infected with or a carrier of: ☐ Hepatitis ☐ HIV ☐ Gonorrhea/syphilis

Please list all major surgeries you have had in the last 10 years:_____

_____

_____

Lifestyle:

Which of the following do you do regularly? Please check all that apply:

- ☐ Drive at night
- ☐ Work outdoors
- ☐ Metal/woodworking
- ☐ Commute more than 20 minutes daily
- ☐ Read for long periods
- ☐ Play sports
- ☐ Work on a computer
- ☐ Fish/hunt
- ☐ Ski

Please list any sports or other activities requiring acute vision in which you participate in regularly:

_____

XXXX