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, where did you find out about our office?
Friend/relative☐, Yellow pages☐ Insurance booklet☐ Drive by☐ internet☐Other_____
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

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

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

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**

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

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

Other: ______________________________

Please **list all medications** you are currently taking, or give us your medication 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 ______________ | ☐ Glaucoma ______________ | ☐ Diabetic eye disease ______________
☐ Cataracts ______________ | ☐ Macular degeneration ______________ | ☐ Lazy eye ______________
☐ Diabetes ______________ | ☐ High blood pressure ______________ | ☐ Cancer ______________
☐ Thyroid disease ______________ | ☐ Retinal disease/ or retinal detachment ______________

Other: ______________________________

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FOR OFFICE USE ONLY

DOCTOR'S SIGNATURE: ______________________________ Date: ________