WELCOME

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can.

PATIENT INFORMATION

Today's Date _____/_____/_____

Patient Name _____

Gender M F Age _____ Birth date _____/_____/_____

Address _____

City _____

State _____ Zip _____

Home phone (_____)_____ Cell (_____)_____

Work phone (_____)_____

May we contact you by e-mail / text message ☐Yes ☐ No

E-mail _____

Social Security #_____

Occupation: _____

Hobbies/Activities _____

Patient Employer/School _____

Spouse's Name _____

Birth date _____ SS# _____

If you are a new patient whom may we thank for referring you?

_____

INSURANCE

Who is responsible for this account? _____

Relationship to the Patient _____

Is patient covered by additional insurance? ☐Yes ☐ No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with :

_____ _____ and assign directly to GW Curnutt and Associates all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions.

The above named group may use my health information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

EYE HEALTH HISTORY

Medical Doctor's Name/Clinic _____ Date of last medical exam _____

Name of Eye Doctor/Clinic _____ Date of last eye exam_____

Do you wear glasses? ☐Yes ☐ No Do you wear contacts? ☐Yes ☐ No Type/Brand_____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

Blurred Vision -Distance	☐Yes ☐ No	**Dry eyes**	☐Yes ☐ No	**Macular Degeneration**	☐Yes ☐ No
Blurred Vision -Near	☐Yes ☐ No	**Eye Infection**	☐Yes ☐ No	**Itching Eyes**	☐Yes ☐ No
Burning Eyes	☐Yes ☐ No	**Eye Injury**	☐Yes ☐ No	**Light Sensitive**	☐Yes ☐ No
Color Vision, Poor	☐Yes ☐ No	**Eye Pain**	☐Yes ☐ No	**Loss of Vision**	☐Yes ☐ No
Discharge from Eyes	☐Yes ☐ No	**Floaters or Spots**	☐Yes ☐ No	**Seeing Flashes**	☐Yes ☐ No
Double Vision	☐Yes ☐ No	**Glaucoma**	☐Yes ☐ No	**Watering Eyes**	☐Yes ☐ No

FAMILY MEDICAL HISTORY

Please note any immediate family member, (Father, Mother, Brother, Sister, Daughter, or Son) with any of the following conditions :

Disease/Condition		**Relationship to you**
Cancer	☐Yes ☐ No	_____
Type 1 Diabetes	☐Yes ☐ No	_____
Type 2 Diabetes	☐Yes ☐ No	_____
High Blood Pressure	☐Yes ☐ No	_____
Hyperthyroid	☐Yes ☐ No	_____
Hypothyroid	☐Yes ☐ No	_____
Cataract	☐Yes ☐ No	_____
Macular Degeneration	☐Yes ☐ No	_____
Glaucoma	☐Yes ☐ No	_____

Please turn this form over and complete side two

Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

AIDS/HIV	☐Yes ☐ No	**Epilepsy**	☐Yes ☐No	**Migraine Head Aches**	☐Yes ☐ No
Arthritis	☐Yes ☐ No	**Hay Fever**	☐Yes ☐No	**Multiple Sclerosis**	☐Yes ☐ No
Asthma	☐Yes ☐ No	**Heart Condition**	☐Yes ☐No	**Retinal Disease**	☐Yes ☐ No
Bleeding Disorder	☐Yes ☐ No	**Hepatitis (Type_____)**	☐Yes ☐No	**Shingles**	☐Yes ☐ No
Cancer	☐Yes ☐ No	**High Blood Pressure**	☐Yes ☐No	**Skin Conditions**	☐Yes ☐ No
Diabetes	☐Yes ☐ No	**High Cholesterol**	☐Yes ☐No	**Stroke**	☐Yes ☐ No
Drug Sensitivity	☐Yes ☐ No	**Kidney Disease**	☐Yes ☐No	**Thyroid Conditions**	☐Yes ☐ No
Emphysema	☐Yes ☐ No	**Lupis**	☐Yes ☐No	**Tubercolosis**	☐Yes ☐ No

Other medical conditions not noted above_____

_____

Pregnant or Nursing? ☐Yes ☐ No

Alcohol use amount and frequency _____

Tobacco use amount and frequency _____

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

Pharmacy Name _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name _____ Relationship_____ Phone # (_____) _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and if applicable, Medigap benefits, be made either to me or on my behalf to GW Curnutt and Associates for any services furnished to me by that provider. to the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian, or Personal Representative — Date

_____ _____

Please Print name of Beneficiary, Guardian, or Personal Representative — Date

GW Curnutt and Associates
2020 Columbia Blvd
St. Helens OR 97051-1737
Phone (503) 397-4911 Fax (503) 397-3986

_____ _____

Doctor's Signature — Date