

Welcome

Joseph D Gilbuena, OD

Affil. with Hallmark Opticians

Name (Last, First, Middle) _____
Address _____ City _____ State ____ Zip _____
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Other _____ Email _____
SS# _____ Employer _____
Birth Date _____ Age ____ Occupation _____
Hobbies _____
M ____ F ____ Single ____ Married ____ Other ____ Student: Full time ____ Part time ____
How did you learn about us? _____

RESPONSIBLE FOR BILLING

Name (Last, First, Middle) _____
Mailing Address (If different from above) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Other _____ Email _____
SS# _____ Employer _____

We will bill your insurance as a courtesy to you. However, you are still responsible for your account.
If your insurance does not pay or pays less than expected, it is your responsibility.
A service charge of 1.5% per month will be imposed on all accounts 30 days past due.
A minimum of \$25.00 fee will be assessed for any NSF checks.

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group # _____
Name of Insured _____ Birth Date _____
Secondary Insurance _____ ID# _____ Group # _____
Name of Insured _____ Birth Date _____

ASSIGNMENT and RELEASE

I authorize the doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I hereby authorize payment directly to the Providing Doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Eye Conditions: Do you experience ...? (Check all that apply, with glasses or contacts on)

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Fluctuating Vision	<input type="checkbox"/> Distorted Vision	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Limited Side Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Burning
<input type="checkbox"/> Excess Tearing	<input type="checkbox"/> Dryness	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Tired Eyes
<input type="checkbox"/> Droopy Eyelid	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Flash of Lights
<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Trouble seeing at night		

Have you been diagnosed or treated for?

<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Other _____	

Have you or a blood relative been diagnosed or treated for? **Self or Family**

S F Glaucoma	S F Cataracts	S F Macular Degeneration
S F Retinal Detachment	S F Blindness	S F Turned/Lazy Eye
S F Diabetes	S F Hypoglycemia	S F Thyroid

Contact Lens History

Do you wear Contact Lenses? Yes / No How many hours are you wearing them? _____ Hrs

How often do you replace them? _____ days / weeks / months / yearly

CURRENT PERSONAL MEDICAL HISTORY:
 General Health: _____ Good _____ Fair _____ Poor

SOCIAL HISTORY:
 Do you drive? Yes / No Please describe any visual difficulties you may have while driving: _____

Do you use tobacco?	Yes / No	If yes, type/amount/how long _____
Do you drink alcohol?	Yes / No	If yes, type/amount/how long _____
Do you use illegal drugs?	Yes / No	If yes, type/amount/how long _____

Are you currently pregnant or nursing? Yes / No

Please list any medications you are taking, including birth control _____

Are you allergic to any medications Y N If yes, please list _____

REVIEW OF SYSTEMS

Do you or your family have any problems with any of the following?
 (Circle No, Self or Family for all that apply) If Yes, please explain below.

N S F Constitutional: fever/weight loss or gain	N S F Gastrointestinal: diarrhea, constipation
N S F Integumentary: skin diseases	N S F Genitourinary: genital, kidney, bladder
N S F Neurological: migraines, seizures	N S F Hematological/Lymph: blood disease
N S F Endocrine / Exocrine: diabetes, thyroid, glandular	N S F Bones/Joints/Muscles: bones or muscle
N S F Ears, Nose, Throat: infections, congestion	N S F Immunological: autoimmune, cancer
N S F Respiratory: asthma, bronchitis, emphysema	N S F Psychiatric: depression, bipolar, anxiety
N S F Cardiovascular: hypertension, heart disease, vascular	N S F Have you been exposed to: Hepatitis, HIV / AIDS, Tuberculosis or Other communicable disease

If Yes, please explain: _____

Date Reviewed _____	Patient initials _____	Doctor initials _____
Date Reviewed _____	Patient initials _____	Doctor initials _____
Date Reviewed _____	Patient initials _____	Doctor initials _____