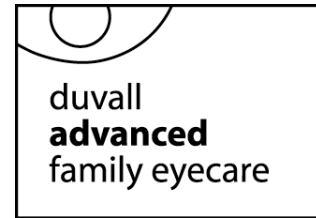


Welcome to Our Office

Suzan B. Grimm, OD, FAAO

Bradford B. Grimm, OD, FAAO



Patient Information

How do you prefer to be addressed?: First name Other name _____ Ms. Mrs. Mr. Miss Dr.

Last Name: _____

Please check your preferred contact phone:

First Name: _____ MI _____

Home Phone: (____) _____

(Mail) Address: _____

Work Phone: (____) _____

Address: _____

Cell Phone: (____) _____

City: _____ State: _____

E-Mail: _____

Zip: _____

Employer: _____

Birth date: _____

Occupation: _____

Female Male ~ Single Married Widowed Separated Other

Contact preferences: If necessary, may we leave a detailed message concerning your care on your voice mail? Yes No

Parents or Spouses Name: _____

Insurance: *Please provide your medical and vision insurance cards to the receptionist to copy.*

Subscriber (if other than patient): Date of Birth: _____

Subscriber (Secondary) Date of Birth: _____

Primary Insurance: _____

Secondary Insurance: _____

Subscriber: _____

Subscriber: _____

ID/SS#: _____ Group #: _____

ID/SS#: _____ Group#: _____

Employer: _____

Employer: _____

Relationship: _____

Relationship: _____

Outside Home Emergency Contact:

Name: _____

Phone: (____) _____

Address: _____

Relationship: _____

How did you hear about our office?

Friend or relative. Who may we thank? _____

Duvall Chamber of Commerce Directory

Referred by physician. Who? _____

Yellow Pages. Which directory? _____

Web site. Which? _____

Newspaper advertisement.

Insurance plan provider list.

Direct mail postcard

Sign / Drive by

Other _____

I authorize treatment of the person named above and agree to pay all fees for such treatment. I understand that payment is required at the time services are rendered, unless other arrangements have been made in advance. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for any non-covered services, deductibles, co-pays and for charges incurred by a collection agency in collecting any unpaid balances. I also authorize the doctor to release any information required. I acknowledge that I have had the opportunity to read and request a copy of the Duvall *Advanced* Family EyeCare, P.S. Notice of Privacy Practices.

Signature of responsible party

Date



Eye and Medical History

Date _____
 Name _____
 Date of birth _____ Age _____
 Primary care doctor _____ Phone _____
 Other doctors you currently see _____
 Date of last eye exam _____ Prior eye doctor _____

Eye Concerns

Have you had: (Please check any appropriate)

- Eye laser treatment
- Eye surgery
- Retinal detachment
- Lazy or crossed eye
- Other significant eye problem _____
- Glaucoma
- Cataract
- Serious eye injury
- Macular degeneration

Are you currently experiencing: (Please check any appropriate)

- Blurred vision
- Dry, irritated eyes
- Red eyes
- Floaters
- Flashes of light
- Other current symptoms _____
- Eye strain
- Reading difficulty
- Double vision
- Eye pain
- Excessive light sensitivity

Please list any complaints about wearing glasses or contacts:

- Do you have only 1 pair of current Rx glasses? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you spend a lot of time outdoors? No Yes
- Do your eyes bother you when using a computer? No Yes
- If you wear bifocals, are you bothered by restricted windows, lines, or head tilting? No Yes
- Are there times you would rather not wear glasses? No Yes
- Are you bothered by glare and reflections? No Yes
- If you wear contact lenses, are you having any problems with vision and comfort? No Yes
- Would you like information about laser vision correction? No Yes

Please tell us about your hobbies and sports activities:

Current Medications (Please list) **No medication**

Medication Allergies? (Please list) **No medication allergies**

Medical History (Please check if you've had any of these problems)

- No medical problems**
- Diabetes
- Hypertension
- Cholesterol
- Heart disease
- Stroke
- Arthritis
- Severe or frequent headache
- Drug / alcohol dependency
- Ear / Nose / Throat disease
- Now pregnant or nursing
- Chronic fever / fatigue / unexpected weight loss or gain
- Other _____
- Thyroid
- Digestive or intestinal
- Asthma or emphysema
- Environmental allergies
- Skin ailments
- Neurologic
- Psychiatric or emotional
- Liver disease
- Cancer
- AIDS or HIV +

Surgical History (Please list procedure and year)

Social History

- Employed? No Yes Student Disabled? No Yes
- Use tobacco? No Yes If yes, how much? _____
- Drink alcohol? No Yes If yes, how much? _____

Family History (Please check any appropriate) **None**

- Glaucoma
- Retinal detachment
- Macular degeneration
- Blindness
- Crossed or lazy eye
- Diabetes
- Hypertension
- Stroke
- Heart disease
- Cancer

Office Use Only

Reviewed	Reviewed	Reviewed	Reviewed	Reviewed