

Fontana Eyecare Associates

Dr. Jeffrey A. Kempf

Dr. Alex J. Amann

WELCOME TO OUR OFFICE

_____ Nickname _____ Date _____

Name (First) _____ (Middle) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

e-mail _____ How would you prefer to be contacted?

Birth Date _____ Age _____ Hobbies _____

Marital Status:

Spouse _____ (Our Patient?) Who recommended us? _____

If child: Parent or Guardian _____

Educational Level Completed: _____ College: _____ Graduate School _____

Occupation _____ Employer _____

Social Security # _____ Medicare # _____

I have received a copy of Fontana Eyecare Associates Notice of Privacy Practices _____
Patient initials _____ Date _____

I hereby authorize Fontana Eyecare Associates to use and disclose my medical and financial information with the person(s) identified below. It is at my request, that the specific information that may be used and disclosed to this person(s), includes any and all of my personal health information in the records of the Practice that pertain to me.

Name Relationship

Name Relationship

Name Relationship

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of _____.

We require payment when services are rendered. If you are using any kind of insurance, it is your responsibility to provide us with your benefit information prior to your examination. The filing of a claim DOES NOT GUARANTEE PAYMENT from your insurance company. Having more than one insurer DOES NOT mean your services are covered 100%.

Will you be paying for today's services by: Cash, Check, Mastercard, Visa, Discover, Care Credit

Signature _____ Date _____

PLEASE TURN PAGE OVER

MEDICAL INFORMATION

Ocular History: Do you wear glasses? _____ Contact Lenses? _____ Type _____

Are you interested in: Contact lenses? _____ Refractive Surgery? _____ Corneal Refractive Therapy? _____

Date of last exam _____ Doctor's Name _____

Were your eyes dilated? _____ If YES: any complications? _____

What was prescribed? Medication _____ Glasses _____ Contacts _____ Therapy _____ Other _____

Many conditions and medications affect your eyes and vision. Please list ALL medications (Rx, OTC and supplements)

and what they are for (or provide list): _____

REVIEW OF SYSTEMS: PLEASE CHECK (✓) IF ANY APPLY (OR ADD AN "R" FOR A BLOOD RELATIVE):

Allergic/Immunologic

- ___ drug allergy
- ___ environmental allergy
- ___ rheumatoid arthritis
- ___ lupus
- ___ other

List Drug Allergies

- none
- _____
- _____
- _____

Gastrointestinal

- ___ Crohn's
- ___ colitis
- ___ ulcer
- ___ digestive
- ___ other

Skin

- ___ eczema
- ___ rosacea
- ___ psoriasis
- ___ dry
- ___ other

Psychiatric

- ___ depression
- ___ panic disorder
- ___ schizophrenia
- ___ other

Heart

- ___ heart disease
- ___ hypertension
- ___ stroke
- ___ vascular disease

Endocrine

- ___ diabetes (insulin)
- ___ diabetes (non-insulin)
- ___ thyroid
- ___ hormone

Genitourinary

- ___ pregnant
- ___ herpes
- ___ HIV
- ___ other

Respiratory

- ___ asthma
- ___ bronchitis
- ___ emphysema
- ___ COPD
- ___ sleep apnea

Neurologic

- ___ multiple sclerosis
- ___ epilepsy
- ___ migraine
- ___ other

Muscle/Skeletal

- ___ fibromyalgia
- ___ muscular dystrophy
- ___ osteoarthritis
- ___ ankylosing spondylitis
- ___ other

Blood/Lymph

- ___ anemia
- ___ leukemia
- ___ blood loss
- ___ other

Constitutional

- ___ developmental disability
- ___ weight loss
- ___ fever
- ___ fatigue
- ___ trauma
- ___ other

Social

- ___ alcohol
- ___ drinks / week
- ___ smokeless tobacco
- ___ current smoker
- _____ per day
- ___ former smoker

Eyes

- ___ cataract
- ___ glaucoma
- ___ macular degeneration
- ___ floaters/flashes
- ___ lazy eye
- ___ temporary vision loss

- ___ color blindness
- ___ eye pain
- ___ dry eye
- ___ retinal problems
- ___ blurred vision
- ___ glare

LIST ALL EYE SURGERIES & INJURIES, INCLUDING DATES AND DOCTOR: _____