Fontana Eyecare Associates

Dr. Jeffrey A. Kempf **Dr. Alex J. Amann**

WELCOME TO OUR OFFICE

Mr., Mrs., Ms., Miss, Dr., Other _____ Nickname _____ Date _____

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

Address _____ City _____ State _____ Zip_____

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

e-mail _____ How would you prefer to be contacted? home / work /cell / text / e-mail

Birth Date _____ Age _____ Hobbies _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse _____ (Our Patient? Yes/No) Who recommended us?_____

If child: Parent or Guardian _____

Educational Level Completed: 7 8 9 10 11 12 College: 1 2 3 4 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? (Y/N) Contact Lenses? (Y/N) Type _____

Are you interested in: Contact lenses? (Y/N) Refractive Surgery? (Y/N) Corneal Refractive Therapy? (Y/N)

Date of last exam _____ Doctor's Name_____

Were your eyes dilated? (Y/N) 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 (Y / N)
___ 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:_____

_____