GATEWAY VISION
GENERAL INFORMATION
(Please Print)

Patient Name: Last, First, MI (Preferred Name)

If patient is a Child - Parent / Guardian Name

Street Address:

City, State, Zip code

Date of Birth Age

Male / Female

Contact Phone # Type: cell home work

Alternate Phone # Type: cell home work

E-Mail address

Preferred Contact Method: Phone E-mail Text

Employer Occupation *Full Time /Part Time*

Marital Status *Married / Single / Divorced / Legally Separated / Widowed / Domestic Partner*

Language, Ethnicity

Hobbies:

Primary Care Physician Phone#

Emergency Contact Person and Phone #

Vision Insurance: Member Name:

Medical Insurance: Member Name:

I give Gateway Vision's Doctors and Staff permission to share my personal and medical information with the following people:

Name: Phone # Rel. to Pt:

Name: Phone # Rel. to Pt:

ACKNOWLEDGMENT OF PRIVACY POLICY & PRACTICES

I understand that in the attempt to protect the privacy of my identifiable health information, Gateway Vision has established a Privacy Policy within its medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPPA Regulations, a copy of the Gateway Vision Privacy Policy & Practices has been made available to me while in the office today. Should I need a personal copy, one will be given to me.

__________ I have read, understood,and acknowledged the Privacy Policy & Practices of Gateway Vision

__________ I have elected NOT to read the Privacy Policy & Practices of Gateway Vision

__________ A copy of the Pivacy Policy & Practices was given to me today, at the office of Gateway Vision

Signature: Date

GATEWAY VISION
MEDICAL INFORMATION

Patient Name: Last, First, MI (Preferred Name)

EYE HISTORY

DATE OF LAST EXAM
I NOW WEAR GLASSES / CONTACTS / BOTH
I NEED NEW GLASSES / CONTACTS / BOTH
REASON FOR VISIT TODAY?

HAVE YOU OR A FAMILY MEMBER EXPERIENCED OR BEEN TREATED FOR ANY OF THE FOLLOWING:

CATARACTS	YOU	FAMILY
CROSSED EYE	YOU	FAMILY
GLAUCOMA	YOU	FAMILY
LASIK OR RK	YOU	FAMILY
LAZY EYE	YOU	FAMILY
MACULAR DEGENERATION	YOU	FAMILY
RETINAL DETACHMENT	YOU	FAMILY

ARE YOU EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING?

- ☐ BLURRY VISION
- ☐ BURNING
- ☐ DISCHARGE
- ☐ DOUBLE VISION
- ☐ DRYNESS
- ☐ EXCESS TEARING/ WATERING
- ☐ EYE PAIN OR SORENESS
- ☐ FLOATERS OR SPOTS
- ☐ HALOS
- ☐ HEADACHES
- ☐ ITCHING
- ☐ LIGHT FLASHES
- ☐ LIGHT SENSITIVITY
- ☐ REDNESS
- ☐ INJURY - EXPLAIN BELOW:
- ☐ EYE SURGERY - EXPLAIN BELOW:

MEDICAL HISTORY

BLOOD PRESSURE LOW / NORMAL / HIGH
HEIGHT WEIGHT
ARE YOU PREGNANT OR NURSING?
DO YOU SMOKE
DO YOU DRINK ALCOHOL YES / NO / PAST

HAVE YOU OR A FAMILY MEMBER EXPERIENCED OR BEEN TREATED FOR ANY OF

IMMUNE PROBLEMS	YOU	FAMILY
ARTHRITIS	YOU	FAMILY
ASTHMA	YOU	FAMILY
CANCER	YOU	FAMILY
DEPRESSION	YOU	FAMILY
DIABETES	YOU	FAMILY
HEART DISEASE	YOU	FAMILY
HEPATITIS	YOU	FAMILY
HIGH BLOOD PRESSURE	YOU	FAMILY
HIGH CHOLESTEROL	YOU	FAMILY
SEIZURES	YOU	FAMILY
STROKE	YOU	FAMILY
THYROID DYSFUNCTION	YOU	FAMILY
TUBERCULOSIS	YOU	FAMILY

OTHER: EXPLAIN

CURRENT MEDICATION AND SUPPLEMENTS

ALLERGIES

Patient / Guardian signature Date