PATIENT INFORMATION – PLEASE COMPLETE BOTH SIDES OF THIS FORM

Please circle the name of the physician your appointment is with:

Thomas C. Gettelfinger, M.D.
John M. Freeman, M.D.
James F. Freeman, M.D.
W. David Irvine, M.D.
Hal B. Wright, M.D.
Brian M. Jerkins, M.D.

Ethnicity:
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Last Name	First Name	Middle	Marital Status	Date of Birth	Age	Social Security	Race

Street Address	City	State	Zip	County	Home Area Code/Phone	Cell Area Code/Phone

Email Address	Reponsible Party, Phone and Address (If other than Patient)

Emergency Contact	Relationship	Area Code/Phone	Address

Patient Employer	Employer Address	Work Area Code/Phone	Occupation
Name of Spouse	Spouse Employer	Work Area Code/Phone	Occupation

INSURANCE INFORMATION

Medicare Policy Number	Name of Primary Care Physician	Physician Phone	Physician Address, City, State, Zip

Insurance Company Name	Address	Phone	Policy No.	Program Sponsor
Insurance Company Name	Address	Phone	Policy No.	Program Sponsor

In order to control billing costs, we request that office visits be paid at time services are rendered. The following authorization release is needed for completing insurance claims. Please sign.

I request that payment of authorized insurance benefits be made on my behalf to my physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to my insurance company or its agents any information needed to determine these benefits or the benefits payable for related services.

Remember to Complete Both Sides →

Patient's Signature

Date

NOV 2015 FPS 30940

NAME **Today's Date:** **Date of Birth:** **Age:**

List or circle any problems you have with your **general health.**

Diabetes
High Blood pressure
Strokes
Asthma
Emphysema
Blood Thinners
Other:

For Office Use:

What **medications, pills or eye drops** do you use?

List any **previous eye surgeries**, surgeon, and dates:

What is your **occupation** or business?

What is your eye problem today?

Do you wear: ☐ Glasses ☐ Contacts ☐ Soft ☐ Hard

Brand, Diameter, Power of Lenses (if known)

____

Date you last wore contacts______________________________

List any **recent surgeries**, surgeon & dates:

List any **allergies** to medications

Pharmacy Name

Area Code/Phone #

List any **family history** of eye disease:

Cataract
Glaucoma
Other:

Address, City, ST, Zip

Name of your **General Physician**: Address Phone

Person or physician referring you to our office: Address Phone

For Office Use:

Date	Procedure	Surgeon	Date	Procedure	Surgeon