PATIENT INFORMATION

Name _____ Date _____
Last Name First Name Middle Initial

Home Address _____ e-mail address _____

City _____ State _____ Zip Code _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Other _____

Patient Employed by _____ Occupation _____

Last exam Date _____ Soc. Sec. # (if necessary) _____

Home Phone _____ Mobile phone _____

Whom may we thank for referring you? _____

What is your reason for visit? _____

Will you accept text messages? YES or NO Will you accept e-mail? YES or NO

CONDITIONS Check conditions you have or have had in the past.

☐ Blurred Vision	☐ Eye Infection	☐ Headaches	☐ Seeing Haloes
☐ Cataracts	☐ Eye Injury	☐ Hypertension	☐ Sensitivity to Light
☐ Crossed Eyes	☐ Eye Surgery	☐ Loss of Vision	☐ Wear Contact Lenses
☐ Diabetes	☐ Floaters	☐ Retinal disease	Type of Lenses _____
☐ Double Vision	☐ Glaucoma	☐ Seeing Flashes	Hours Per Day _____

Check if your blood relatives had any of the following:

	Disease	Relationship to You
	Blindness	
	Cataracts	
	Diabetes	
	Macular degeneration	
	Glaucoma	

ALLERGIES you have to medications or substances.

MEDICATIONS List medications you are currently taking.

INSURANCE INFORMATION

Person Responsible for Account _____
(If different than above) Last Name First Name Middle Initial

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address (if different than above) _____ Phone _____

City _____ State _____ Zip Code _____

Responsible Party Employed By _____ Sex ☐ M ☐ F

Primary Insurance Co. _____ Group # _____

Phone # _____

AUTHORIZATIONS

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____

and assign directly to Dr. Russell R. Gist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information deemed necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible Party _____ Date _____