Welcome to Giron Family Vision Gallery, LLC.

Last Name: _____First Name: _____Date: _____

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Texting Okay? □Yes □ No

Gender: □Female □Male □Other Email: _____

Name of Legal Guardian: _____ S.S.N: _____
(if under the age of 18) (SSN is only required when using insurance)

Why did you come to see us today?
(Check all that apply).

□ I am not having any specific eye problems (annual eye exam)
□ I have an eye disease requiring examination
□ I want an exam for glasses
□ I want an exam for contact lenses
□ I want a diabetic eye examination (dilation required, $32 additional fee if no insurance)
□ I want a hydroxychloroquine/Plaquenil eye examination (visual field required, $32 additional fee)
□ I want a dry eye evaluation ($50 additional fee)
□ I am having the following problems: _____

I will be using my: □ Vision Insurance
(VSP, Davis, Superior)

List all medications and supplements you are taking:

_____

_____

List any allergies to medications you have: _____

SOCIAL / ENVIRONMENTAL HISTORY

Employer: _____
Occupation: _____
Marital status: □ Married □ Single □ Other
Are you pregnant? □ Yes □ No
Do you smoke? ❑ Yes ❑ No
Everyday ❑ Occasionally ❑ Former ❑ Never ❑
Do you drink alcohol? □ Yes _drinks/day □ No
Have you had any STD's? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No
Do you have a history of any developmental problems or conditions? ❑ Yes ❑ No

OCULAR HISTORY

(Do you or a family member have the following?)

Cataracts	□ Self	□ Family
Glaucoma	□ Self	□ Family
Macular Disease	□ Self	□ Family
Dry Eye	□ Self	□ Family
Lasik	□ Self	□ Family
Lazy Eye	□ Self	□ Family
Retinal Detachment	□ Self	□ Family

Other _____

Date of last Eye Exam: _____
Please list any Eye Surgeries you have had: _____
What kind of glasses do you wear? ❑ General purpose ❑ reading ❑bifocal ❑progressive
When do you wear your glasses? ❑ Full-time ❑hardly ever ❑ only to drive ☐ only to read

Do you wear contact lenses? □yes □ no

Please print name of the contacts: _____

Prescription of Contacts: _____

What kind of contacts do you wear? □ Daily Disposable □ Toric □ Bifocal □ Monovision

How often do you replace your contacts? □ Daily □ 2-weeks □monthly □ quarterly □ yearly

REVIEW OF SYSTEMS – Do you or a family member currently have any of the following?

Diabetes □ Self □ Family

(If self, please answer the following questions)

Type □ 1 or Type □ 2

Primary Physician Name? _____ Primary Physician Fax Number? _____

Date Diagnosed? _____ Last A1C level? _____ Last blood sugar reading? _____

Hypertension	□ Self	□ Family	**Asthma**	□ Self	□ Family
High Cholesterol	□ Self	□ Family	**Stroke**	□ Self	□ Family
Thyroid Condition	□ Self	□ Family	**Skin Disease**	□ Self	□ Family
Tumor/Cancer	□ Self	□ Family	**Psychological Condition**	□ Self	□ Family
Gastro Disease	□ Self	□ Family	**Neurological Disease**	□ Self	□ Family
Immune Disease	□ Self	□ Family	**Blood Disease**	□ Self	□ Family
Bleeding Disorder	□ Self	□ Family	**Ear/Nose/Throat Disease**	□ Self	□ Family
Heart Disease	□ Self	□ Family	**Kidney Disease**	□ Self	□ Family
HIV/Hepatitis/Herpes	□ Self	□ Family			

I give consent for treatment by the doctor of Giron Family Vision Gallery. I understand that payment is due at the time of service. My insurance company will be filed on my behalf by the staff of Giron Family Vision Gallery. I authorize any holder of my medical information to release such information to any agency necessary to determine benefits payable, compliance or utilization. I authorize and direct my insurance carrier(s) to issue payment for services rendered to Giron Family Vision Gallery. Benefits are determined by the contract between you, as the covered member, and your insurance company. I understand that payment for services are ultimately my responsibility and I agree to pay all incurred charges in full immediately upon receipt of a statement from the practice of Giron Family Vision Gallery. I further understand that glasses that were purchased from Giron Family Vision Gallery are **NON-REFUNDABLE,** due to the fact that they were custom made. In addition, there are **NO REFUNDS** for any professional services. I also understand and agree that the practice may amend such terms from time to time. I further understand that re-examinations after **30 DAYS** will be subject to additional $45 fee, and after 6 months a whole new eye examination will be required. Giron Family Vision Gallery requires that all new patients are to be dilated by drop or opt for retinal imaging **(additional $32 charge**), at the time of their first appointment. Under federal law, I confirm that I have received a copy of my eye glass prescription.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms.

HIPAA COMPLIANCE ACKNOWLEGEMENT OF RECEIPT

I understand the HIPPA Compliance laws of Giron Family Vision Gallery, and a copy shall be provided at my request.

Patient Signature: _____ **Date:** _____