



# GRAYHAWK EYE CENTER, PLLC.

Date \_\_\_\_\_

Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street Apt # City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Email Address \_\_\_\_\_

May we contact you?  Yes  No

Check one: Male  Female  Check one: Single  Married  Divorced  Widowed

Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

### GUARDIAN/SPOUSE INFORMATION:

Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
(If Different From Above) Street Apt # City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION: (Other than spouse/not living at same address)

Name \_\_\_\_\_  
First Middle Last

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

In a brief statement, tell us the reason for your visit today. \_\_\_\_\_

Please list eye medication(s) and dosage(s) taken on a regular basis. \_\_\_\_\_

Please list all prescription medication(s) and dosage(s) taken on a regular basis. \_\_\_\_\_

How old is your current prescription for contact lenses, glasses? \_\_\_\_\_

### PRIMARY CARE PHYSICIAN

Name \_\_\_\_\_ Phone # \_\_\_\_\_

### OPTOMETRIST

Name \_\_\_\_\_ Phone # \_\_\_\_\_

**FAMILY HISTORY: In your family history, do any of the following apply? If so, who?**

Cataracts \_\_\_\_\_  Glaucoma \_\_\_\_\_  
 Diabetes \_\_\_\_\_  Other eye disorders/diseases \_\_\_\_\_

**Do you have any of the following problems? (Please check those that pertain to you.)**

Diabetes  Heart Problems  Sinus  Seizures  
 High Blood Pressure  Kidney Problems  Dentures  Shortness of Breath  
 Chronic Bronchitis  Hearing Impaired  Dizziness  Chest Pain  
 Tuberculosis  Asthma  Smoker  Hepatitis  
 High Cholesterol  Bleeding Disorder  Bladder Problems  Other (use line below)

Allergic to any medications?  Yes  No If Yes \_\_\_\_\_

To the best of your knowledge do you have HIV, Aids, or Aids-Related Complex?  Yes  No

To the best of your knowledge are you pregnant?  Yes  No

Previous Surgeries in your lifetime (include childhood): \_\_\_\_\_

Tonsillectomy  Appendectomy  Hysterectomy  Prostate  Gall Bladder

**INSURANCE INFORMATION:**

Primary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ SS# & DOB \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ SS# & DOB \_\_\_\_\_

**PATIENT'S RIGHTS AND RESPONSIBILITIES:**

1. Release of information:

I hereby give consent to Grayhawk Eye Center, PLLC., and Associates to release any information regarding my care and treatment as may be required by any insurance carrier for any portions of my bill.

2. Responsibilities for payment/patient agreement:

I understand that the doctors at Grayhawk Eye Center, PLLC., and Associates are not responsible for deductibles made by any insurance company, government agency, HMO/PPO plans, etc. I agree to pay any portion of fees charged by Grayhawk Eye Center, PLLC., and Associates for services rendered to me that are not covered by my insurance company.

3. Assignments of benefits:

I authorize my insurance company to assign benefits to Grayhawk Eye Center, PLLC., and Associates

I have read and understand the above

\_\_\_\_\_  
Patient or Guarantor Signature

\_\_\_\_\_  
Date