Welcome to the office of Dr. Christine Gebhardt
…We are here to address all of your
Visual & Eye Health Concerns…

Patient Information:
Today's Date: ____________________

Name: ____________________

Address: ____________________

____
City State Zip

Phone Numbers: Home ____________________

Work or Cell ____________________

E-MAIL ____________________

Birthdate: ____________________ Age: __________

Sex: ☐ Male ☐ Female

Marital Status: ☐ single ☐ married ☐ divorced ☐ widow ☐ other

Occupation: ____________________

Employer: ____________________

Employment Status: ☐ employed ☐ FT student ☐ PT student

How were you referred to our office? ____________________

Personal Medical History:
What is the main reason for today's visit? ____________________

____

Name of Medical Doctor: ____________________

Are you **allergic** to any medications? ☐ No ☐ Yes
If yes please list.

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Many medicines can have side effects that affect the eyes. **Please list any medications including over the counter medicines that you are taking.** If there are too many to list please provide a written summary from your pharmacy that we can copy or name them for Dr. Gebhardt during your exam.

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Personal Vision History:

Do You Wear Glasses	☐ No	☐ Yes
Do You Wear Contact Lenses	☐ No	☐ Yes
Have you had LASIK ?	☐ No	☐ Yes
Are you considering having it in the future?	☐ No	☐ Yes

Family Vision & Health History:
Please note if you or any family members (parents, grandparents, siblings, children) have any of the following conditions.

		Relationship to you
Blindness	☐ No	☐ Yes__________
Cataracts	☐ No	☐ Yes__________
Crossed Eyes	☐ No	☐ Yes__________
Eye Surgeries	☐ No	☐ Yes__________
Glaucoma	☐ No	☐ Yes__________
Macular Degeneration	☐ No	☐ Yes__________
Retinal Detachment	☐ No	☐ Yes__________
Arthritis	☐ No	☐ Yes__________
Cancer	☐ No	☐ Yes__________
Diabetes	☐ No	☐ Yes__________
Average FBS/ HbA1C	__________	
Elevated Cholesterol	☐ No	☐ Yes__________
Heart Disease	☐ No	☐ Yes__________
High Blood Pressure	☐ No	☐ Yes__________
Kidney Disease	☐ No	☐ Yes__________
Thyroid Disease	☐ No	☐ Yes__________
Autoimmune Disease	☐ No	☐ Yes__________
STD	☐ No	☐ Yes__________
Other	☐ No	☐ Yes__________
Do you smoke?	☐ No	☐ Yes__________

Responsible Party / Vision Insurance Information:

Name of Insured: ____________________

Patient's Relationship to Insured:

Self ☐ Spouse ☐ Child/Dependent ☐

Insurance Company: ____________________

Please give your insurance card to our receptionist so that we may make a photocopy.

Assignment & Release:
I, the undersigned certify that I (or my dependent) have insurance coverage at the time of service and assign directly to Dr. Christine Gebhardt 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 necessary to secure payment of benefits and bill on my behalf. I authorize the use of this signature for all insurance submissions. I understand that my personal information will be kept confidential as outlined by HIPPA. I further acknowledge receipt of the HIPPA Privacy Practices brochure.

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Responsible Party Signature **Date**