Welcome to Great Plains Vision, LLC.

Date___/___/_____

Prefix (Circle One)

Last Name First Name Mr. Mrs. Ms. Dr. Birth Date

Address City State Zip Code Social Security #

Primary Phone # Secondary Phone # Email Address Height Weight

Emergency Contact (Not living with you) _____ Relationship _____
Address _____ Phone # _____

Race: (Circle One)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

Ethnicity: (Circle One)
Hispanic or Latino
Not Hispanic or Latino

Marital Status: (Circle One)
Single
Married
Divorced
Other

Employment: (Circle One)
Employed
Retired
Student
Other

Preferred Language:
English
Spanish

New Patients Only:
Who may we thank for referring you to our office? Name of friend or relative _____
If not referred, how did you choose our office? (Please Circle One)

Another Doctor Saw Sign/Building Yellow Pages
Insurance List Newspaper/Radio/TV Website

Medical History
Name of Physician _____
Date of last eye exam _____
What brings you to our office today? _____
List the medications you are taking including vitamins, herbal remedies, prescribed, or over the counter:
_____
_____
Do you have any allergies to medications? Yes ___ No ___ If yes, please explain _____
_____
Name of preferred Pharmacy _____
List all major injuries, surgeries, and/or hospitalizations you have had _____
_____
Are you pregnant? Yes ___ No ___ nursing? Yes ___ No ___
Do you wear glasses? Yes ___ No ___ If yes, how old are your current lenses? _____
If you wear bifocals, do the lines or head tilting bother you? Yes ___ No ___
Are you having any problems with your current glasses? Yes ___ No ___
Do you wear contact lenses? Yes ___ No ___ If yes, what type of contacts do you wear? (Circle one)
daily disposables biweekly disposables monthly disposables rigid lenses other

Are you interested in contacts? Yes___ No___
Are you having any problems with your current contact lenses? Yes ___ No ___
Would you prefer clear contact lenses or colored contact lenses? Clear ___ Colored ___

Family History:
Is there a family medical history of any of the following?

Disease/condition	Yes	No	?	Relationship to you
Glaucoma	___	___	___	_____
Cataract	___	___	___	_____
Macular Degeneration	___	___	___	_____
High Blood Pressure	___	___	___	_____
Diabetes	___	___	___	_____

Review of Systems: Do you currently have any problems in the following areas?

Systems	Yes	No	?
Allergies/Immunologic			
Drug Allergy	___	___	___
Environmental/Seasonal	___	___	___
Rheumatoid Arthritis	___	___	___
Lupus	___	___	___
Other	_____		
Eyes			
Glaucoma	___	___	___
Cataracts	___	___	___
Macular Degeneration	___	___	___
Surgery	___	___	___
Inflammatory Disorders	___	___	___
Blurred Vision	___	___	___
Double Vision	___	___	___
Dry Eyes	___	___	___
Itchy Eyes	___	___	___
Headaches	___	___	___
Other	_____		
Musculoskeletal			
Fibromyalgia	___	___	___
Muscular Dystrophy	___	___	___
Osteoarthritis	___	___	___
Ankylosing Spondylitis	___	___	___
Cardiovascular			
Heart Disease	___	___	___
Hypertension	___	___	___
Stroke	___	___	___
Vascular Disease	___	___	___
Other	_____		
Gastrointestinal			
Crohn's	___	___	___
Colitis	___	___	___
Ulcer	___	___	___
Digestive	___	___	___
Other	_____		
Neurological			
Multiple Sclerosis	___	___	___
Epilepsy	___	___	___
Alzheimer's	___	___	___
Parkinson's	___	___	___
Cerebrovascular	___	___	___

Systems	Yes	No	?
Constitutional			
Developmental Disability	___	___	___
Weight Loss	___	___	___
Fever	___	___	___
Fatigue	___	___	___
Trauma	___	___	___
Genitourinary			
STD	___	___	___
Other	_____		
Psychiatric			
Depression	___	___	___
Anxiety Disorder	___	___	___
Schizophrenia	___	___	___
Other	_____		
Ear, Nose, Mouth and Throat			
Upper Resp. Infection	___	___	___
Ear Ache	___	___	___
Runny Nose	___	___	___
Sore Throat	___	___	___
Ringing/Tinitis	___	___	___
Other	_____		
Hematologic/Lymphatic			
Anemia	___	___	___
Large Volume Blood Loss	___	___	___
Leukemia	___	___	___
Other	_____		
Respiratory			
Smoker Status	___	___	
Asthma	___	___	___
Bronchitis	___	___	___
Emphysema	___	___	___
Other	_____		
Endocrine			
Diabetes	___	___	___
Thyroid Dysfunction	___	___	___
Hormonal Dysfunction	___	___	___
Other	_____		
Integumentary			
Eczema	___	___	___
Rosacea	___	___	___
Psoriasis	___	___	___

Insurance/Waiver of Liability and Insurance Signature on file

I certify that the information given by me in applying for Insurance/Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my Insurance/Medicare benefits and payment of these benefits directly to Great Plains Vision, LLC. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. If I have other health insurance coverage (as indicated in item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. If Medicare does not pay for specific parts of my exam, I will be responsible. Medicare does not pay for everything, even some care that my doctor and I have good reason to think I need. I may opt out of the non-covered services. If I want all parts of the exam, all non-covered services will be my responsibility.

Signature _____ *Date* ___/___/_____

Signature of responsible person _____ *Date* ___/___/_____

Doctor's Signature _____ Date ___/___/_____