See Sharp EYEWEAR

David M. Girardi, OD

Patient Demographic Information

Patient Name: _____ _____ _____ __/__/__
(Last) (First) (M.I.) (DOB)

Address: _____ _____
(Street) (Apt/PO Box)

_____ _____ _____
(City) (State) (Zip)

Phone: Home (___)_____ Cell (___)_____ Work (___)_____

E-Mail: _____@_____ Preferred method of contact: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Partnered [ ] Other

Employer/School _____ Occupation _____
Emergency Contact _____ Relationship _____ Phone _____

Insurance

*If you have additional insurance coverage, please notify the staff at the front desk.

Primary Medical	Vision or Secondary
Primary Insured _____	[ ] Same as Medical Insurance
Primary Insured DOB _____	Primary Insured _____
Primary Insured SSN _____	Primary Insured DOB _____
Employer _____	Primary Insured SSN _____
Relationship to Patient _____	Employer _____
Insurance Company _____	Relationship to Patient _____
Member ID _____	Insurance Company _____
Plan Name/Group _____	Member ID _____
	Plan Name/Group _____

Doctor and Pharmacy

Primary Care Physician: _____ Phone: (___)_____
Location: _____ Fax: (___)_____

Pharmacy: _____ Phone: (___)_____
Location: _____ Fax: (___)_____

Assignment and HIPAA Release: I certify that I and/or my dependent (Patient), have insurance coverage with the company(ies) listed above and assign directly to Dr. David M. Girardi, OD LLC, all insurance benefits, if any, otherwise payable to myself for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. David M. Girardi, OD LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date of signature.
I have been given the opportunity to review HIPAA policies and have either declined to review or was given a copy of HIPAA privacy policies. A copy of our policy and HIPAA information is available upon request at the front desk.

Signature of Patient/Primary Insured:_____ Date:_____

Over

Medical History (Treated & Untreated)
Check All That Apply

AIDS/HIV	
Artificial Heart Valve	
Arthritis	
Artificial Joints	
Asthma	
Blindness	
Cancer (Type_____)	
Cataracts	
Diabetes (Type_____)	
Emphysema	
Epilepsy	
Eye Surgery (Date_____)	
Glaucoma	
Hemorrhaging	
Hepatitis (Type_____)	
High Cholesterol	
High Blood Pressure (Hypertension)	
Kidney Disease	
Lupus	
Macular Degeneration	
Migraine Headaches	
Multiple Sclerosis	
Pacemaker	
Retinal Disease	
Shingles	
Skin Condition (Type_____)	
Stroke	
Thyroid Condition(Type_____)	
Tuberculosis	

Medications

Please list any prescribed medications with dosage instructions:
If you have a prepared list, we can photocopy and attach it.
[ ] See attached list.

Medication	Dosage Instruction

Eye Health

Blurred Vision at Near	
Blurred Vision at Distance	
Burning Eyes	
Crossed Eyes	
Discharge	
Dry Eyes	
Eye Injury	
Eye Strain	
Flashes	
Floaters or Spots	
Headaches	
Itching	
Watering Eyes	
Other	

Family Medical History

Condition	Family Member
Blindness	
Cancer (Type_____)	
Diabetes (Type_____)	
Glaucoma	
Macular Degeneration	
Multiple Sclerosis	
Retinal Disease	
Stroke	
Tuberculosis	

Social

Do you Smoke? _____
Have you Ever Smoked? _____
When did you quit? _____

Are you pregnant? _____

Drug Related Allergies

[ ] No known drug allergies

Drug	Reaction