**Patient Information & Medical History Form \***

\*Please print information as it is seen on your insurance card. \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

 Date

**\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title Last First MI Suffix Nickname

\_\_\_\_\_­­\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

No. Street Apt. City State Zip

Cell Phone: (\_ \_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_ Home Phone: (­­\_ \_ \_\_)­­\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_ \_ \_)\_\_ \_\_\_ \_\_\_

Preferred Contact by: email ☐ Text message ☐ Call ☐

Date of Birth (mm/dd/yyyy): ­\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Female ☐ Male ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

Employment status: Employed ☐ Full time student ☐ Part time student ☐

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Information**

Is the billing address the same? Yes ☐ No ☐ (If no, please enter below.)

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

No. Street Apt. City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for the bill Phone number

Do you have Medical Insurance? [ ] yes [ ] no. If yes, name of plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medicare? [ ] yes [ ] no. If yes, name of secondary plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a separate vision plan? [ ] yes [ ] no. . If yes, name of plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If VSP, what are the subscriber’s date of birth and last 4 digits of the SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary physician’s name and phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check the box for any conditions that apply to you or your relatives:

You Mom Dad Sibling

Hypertension ☐ ☐ ☐ ☐

Thyroid ☐ ☐ ☐ ☐

Cardiovascular ☐ ☐ ☐ ☐

Cancer ☐ ☐ ☐ ☐

Diabetes ☐ ☐ ☐ ☐

If YOU are diabetic, when were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last A1C level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only: Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems: Do you have any of the following medical conditions?**

If you answer yes to any of the following problems from head to toe, please specify below:

 Yes No Specify:

|  |  |  |  |
| --- | --- | --- | --- |
| **General:** i.e. fever, fatigue, loss of appetite, weight loss/gain |  |  |  |
| **Ears, Nose, Throat**: i.e. sinus/nasal congestion, nose bleeds, dry mouth/throat, hearing problems |  |  |  |
| **Cardiovascular:** i.e. chest pain, racing heartbeat, swollen feet/ankles, stroke |  |  |  |
| **Respiratory:** i.e. chronic cough, shortness of breath, wheezing |  |  |  |
| **Genital, Kidney, Bladder**: i.e. bladder/urinary problems, discharge, pain, menstrual changes, impotence |  |  |  |
| **Gastrointestinal:** i.e. constipation, diarrhea, gastric reflux (GERD), jaundice, nausea/vomiting |  |  |  |
| **Endocrine:** i.e. heat or cold intolerance, thinning hair, excess thirst/urination |  |  |  |
| **Muscles/Bones/Joints:** i.e. pain, stiffness, swelling, weakness, limited movements |  |  |  |
| **Skin:** i.e. dry, itchy, flaky, rash, growths, bumps, redness, discoloration |  |  |  |
| **Neurological:** i.e. headaches, numbness/tingling, tremors, poor balance, dementia |  |  |  |
| **Psychiatric:** i.e. depression, anxiety, sleep problems, paranoia, obsessive/compulsive |  |  |  |
| **Blood/lymph:** i.e. anemia, bleeding gums, delayed clotting, unexplained bruising |  |  |  |
| **Allergy/Immune:** i.e. swollen lymph nodes, itching, sneezing, runny nose/eyes |  |  |  |

Do you currently smoke? Yes ☐ No ☐ Former smoker ☐

If yes, how many packs a day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use: No ☐ Occasional ☐ 1 drink per day ☐ More than 1 drink per day ☐

Do you live alone? Yes ☐ No ☐ Assisted living ☐ Nursing home ☐

List major injuries or surgeries you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List currently **prescribed medications and dosage** and vitamins/supplements you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any **drug allergies** you have:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **EYE History:**

Who was your previous eye doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the box for any eye conditions that apply to you or your blood relatives:

You Mom Dad Sibling Other relative

Glaucoma ☐ ☐ ☐ ☐ [ ]

Macular degeneration ☐ ☐ ☐ ☐ [ ]

Retinal problems ☐ ☐ ☐ ☐ [ ]

Cataracts ☐ ☐ ☐ ☐ [ ]

Lazy Eye/Eye turn ☐ ☐ ☐ ☐ [ ]

List any major eye injuries or eye surgeries and their dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other significant eye problems you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all eye medications or over the counter drops you are currently using:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any medical eye or vision complaints you are currently having, for example:

 [ ] Seeing halos at night [ ] Dark spots/webs/floaters [ ] Blurry vision

[ ] Headaches [ ] Eyestrain [ ] Double vision [ ] Losing place when reading

[ ] Itching [ ] Burning [ ] Redness [ ] Pain

[ ] Sensitivity to light [ ] Watering [ ] Crusting [ ] Mucus discharge

[ ] Other eye problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per day do you typically spend using a computer or other digital device? \_\_\_\_\_\_\_\_\_ How many hours per day do you typically spend reading books, magazines etc.?\_\_\_\_\_\_\_\_\_

What are your hobbies/sports activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sunglasses? Yes ☐ No ☐

 Do you have back-up glasses? Yes ☐ No ☐

 Do you currently wear contact lenses? Yes [ ]  No[ ]

 Are you interested in contacts? Yes ☐ No ☐

 **HIPAA AUTHORIZATION FORM**

**AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give my consent to **Dr.** **Gregory T.**

**Komm, O.D., P.A.** to use or disclose my protected health information as described below:

**PURPOSE OF THE USE OR DISCLOSURE**

The purpose of this use or disclosure is to carry out treatment, payment, or health care operations.

**ACKNOWLEDGEMENT**

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

**PERMISSION TO DISCUSS INFORMATION**

I give my permission to **Dr. Gregory T. Komm, O.D., P.A.** to discuss any exam findings with the following person(s):

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: [ ] Physician [ ] Spouse [ ] Relative [ ] Parent

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is under 18, parent/guardian signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please print name of parent/guardian if patient is under 18 years old: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office policy notice**: Since our doctors reserve 30 minutes of their time for your appointment, there will be a $50.00 charge for all missed appointments without 24 hour prior notification. Please sign below to acknowledge this notification:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_