

DR. GREGORY T. KOMM, OD., P.A.
MD LICENSE # TA1193

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(301) 881-7422

Patient Information & Medical History Form *

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

Date: ____/____/____
 mm dd yyyy

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 Retired

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? _____

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

	You	Mom	Dad	Sibling
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LazyEye/Eyeturn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Seeing halos at night | <input type="checkbox"/> Dark spots/webs/floaters | <input type="checkbox"/> Blurry vision | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eyestrain | <input type="checkbox"/> Double vision | <input type="checkbox"/> Losing place when reading |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Burning | <input type="checkbox"/> Redness | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Watering | <input type="checkbox"/> Crusting | <input type="checkbox"/> 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: _____