Dr. H. H. Trey Gerdes
Therapeutic Optometrist

Patient Information

Patient's Name (Please Print)_____ Date_____
(Last) (First) (MI)

Mailing Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Business Phone _____ Cell Phone_____

Email_____ Age_____

Birth Date _____/_____/_____ Gender M / F SSN _____-_____-_____

Drivers License #_____ ST_____ Occupation _____

Employer_____ Sports/Hobbies_____

If a student: Grade_____ School Name_____

Name of Parent or Spouse_____

Email Address _____

Have we seen other members of your family? If yes, whom. _____

How Did You Find Out About Our Office? Referred by: _____
Online _____Yellow Pages_____ Family Doctor _____ Other_____

What is the reason for your visit today? _____

Payment & Insurance Information (please circle one)
Cash Check Credit Card Medicare Medicaid Blue Cross VSP Other Insurance _____

Insured's Name _____ Relation to Patient _____

Insured's SS# _____ Insured's D/O/B _____ Insured's Employer _____

Primary Insurance_____ Policy Number_____

Supplemental Insurance _____Policy Number_____

I agree to pay any and all charges that my insurance does not pay or does not cover on the day of my visit. I hereby authorize payment directly to the office of Dr. H.H.Trey Gerdes for any insurance benefits otherwise payable to me for services rendered by this office.
A contact lens prescription is valid for one year. A fitting is to be performed within 3 months of exam to use that prescription for contacts. Contact lens fitting fee is due the day the fitting is done, even if contacts are not purchased. Contact lens fitting fees are not refundable.
A late fee of $10.00 will be applied every 30 days on an overdue account. Collection fees will be added to accounts sent to collections.

Last exam by an Eye Doctor _____ _____
Date NAME ADDRESS PHONE

Primary Care Physician_____
NAME ADDRESS PHONE

Emergency Contact _____Emergency Contact Phone_____

Medical History

What is your general health status? Excellent____ Good ____ Fair____ Poor____ Date of Last Physical _____
Do you have allergies to any medications? ____Yes _____No If yes, explain: _____

Do you have general allergies? ____Yes ____ No Allergic to what? _____
List all medications you are taking. _____

List all major illness, injuries, surgeries and /or hospitalizations within the last 10 years _____

Are you pregnant? ____ Yes ____No If yes, how many months? _____
Explanation of health history, where necessary

(PLEASE COMPLETE THE BACK)

Social History

Does your vision limit activities of daily living? (driving, reading, working, etc) _____Yes _____No

If yes, please describe._____

Do you use tobacco products? ____Yes ____ No If yes, packs per day? _____

Do you drink alcohol? ____Yes ____ No If yes, amount and how often? _____

Do you use illegal drugs? ____Yes ____ No If yes, what type? _____

Please put a check next to the following if you have ever been exposed to or infected with:

____HIV ____Hepatitis ____Tuberculosis ____ Chlamydia ____Gonorrhea

(This information is a protected part of your medical record. It is confidential. However, if you prefer, you may discuss this portion of your medical history directly with Dr. Gerdes.)

Ocular History

Do you wear glasses ____Yes ____ No Using eye drops ____ Yes ____No Brand of drops_____

Do you wear contacts lenses? ____ Yes ____No If yes, what type? _____

List all current or past Eye Disease, Eye Injury, or Eye Surgery._____

Family History	Self	Family	Explain Condition
Blindness			
Cataract			
Glaucoma			
Diabetes			
High Blood Pressure			
Cancer			
Heart Disease			
Thyroid Disease			
Arthritis			
Stroke			
Macular Degeneration			
Other Inherited Disease			

Review of Systems

Please circle to indicate if you currently have any problems in one or more of the following areas? If yes, please explain.

GENERAL/ CONSTITUTIONAL YES NO
(fever, weight loss or gain, tired feeling)

EYES YES NO
(blurred vision, eye pain, discharge, etc.)

EARS/NOSE/ THROAT/ MOUTH YES NO
(Hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.)

RESPIRATORY YES NO
(asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.)

CARDIOVASCULAR YES NO
(diabetes, hypertension, heart problems)

GASTROINTENSTINAL YES NO
(diarrhea, constipation, hernias, ulcers, etc.)

GENITOURINARY YES NO
(painful urination, frequent urination, impotence, jaundice, etc.)

LYMPHATIC YES NO
(anemia, bleeding problems, problems with blood transfusions, etc.)

MUSCULOSKELTAL YES NO
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling etc.)

SKIN YES NO
(pimples, warts, growths, rashes, etc.)

Patient /Guardian Signature _____Date_____