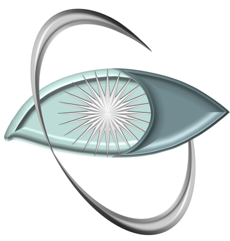

Dr. Gordon W. Jennings   Dr. Amber H. McCulley   Dr. Abigail J. Mitchell

310 East Main Street   Wytheville, VA 24382
P: 276.228.2771   F: 276.228.2771

Date: _______/_________/_________

First Name: ________________________________ MI:____ Last Name: ____________________________________

Address:____ SSN: ___________________________

City: ____ State: _________ ZIP: _____________

Birth Date: _____/_____/_______ ☐ Male ☐ Female Home Phone: (_____)______________

Email (for appointment/order reminders): _______________________________ Cell Phone: (_____) _______________

Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ E-mail

Preferred language: ___________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other_______________

Race: _________________________

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

Ethnicity: ______________________

Responsible Party (if patient is minor or incapacitated adult)

First Name: ________________________________ MI:____ Last Name: ____________________________________

Address(if different from patient): ____

City: ____ State: _________ ZIP: ______________

Birth Date:_____/_____/_______ Phone: (______) ____________________

Emergency Contact

First Name: ________________________________ MI:____ Last Name: _____________________________________

Relationship to Patient: ____________________________________ Phone: (_______) ____________________

Release of Medical Records

To: Custodian of Medical records. This authorizes you to release to Gordon W Jennings OD PC full and complete medical records, reports, evaluations, consultations, or information (collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represent and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein. The undersigned expressly released and forever discharges and agrees to indemnify and hold harmless Gordon W Jennings OD PC, including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Patient or Guardian Signature ____ Date ___/___/_______

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to all providers of the medical benefits, if any: otherwise, payable to me for service rendered by Gordon W Jennings OD PC. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any costs incurred in the collection of such account including reason attorney fees and court costs I hereby waive notice of dishonor, demand, and protest. All exemptions are waived. I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for the payment to Gordon W Jennings OD PC for all service rendered the above patient that are not covered by Medicare assignment, Medicaid, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Patient or Guardian Signature ____ Date ___/___/_______

Acknowledgment of Privacy Policy

I Acknowledge that I have viewed and been offered a copy of the privacy policy for Gordon W Jennings OD PC.

Patient or Guardian Signature ____ Date ___/___/_______

MEDICAL HISTORY QUESTIONNAIRE

Vision History

What is the PRIMARY reason for your visit today?: ______________________________

Name of Primary Care Medical Doctor: ____________________ City/State: ________________

Preferred Pharmacy: ____________________ City/State: ____________________

When was your last eye exam?: ______________________________

Do you wear glasses? ☐ Yes ☐ No How old are your current glasses?: ____________

Do you wear contact lenses? ☐ Yes ☐ No Type of contact lenses: ☐ Rigid ☐ Soft

How often do you replace your lenses? __________ How often do you sleep in your lenses?: __________

Have you had any eye surgery? ☐ Yes ☐ No If YES, what type?: ______________ When?: __________

Are you *currently* experiencing any of the following?

- ☐ Itchy Eyes
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Tired Eyes
- ☐ Headaches
- ☐ Glare/Excess Light Sensitivity
- ☐ Floaters in Vision
- ☐ Loss of Vision
- ☐ Double Vision

Have you *ever* been diagnosed with any of the following?

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Lazy Eye
- ☐ Retinal Disease
- ☐ Eye Injury
- ☐ Retinal Tear/Detach

Medical History

Please check any major illnesses:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes, type: _____ how long?: ________
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Heart Attack
- ☐ Stroke
- ☐ Autoimmune Disease
- ☐ Arthritis
- ☐ Migraines
- ☐ Cancer, type: ____________
- ☐ Other: ____________

Are you currently pregnant or nursing? ☐ Yes ☐ No

Please provide a list of any prescription and nonprescription medications you are taking, including vitamins & herbal supplements OR provide consent for us to obtain your medications electronically from your pharmacy:

☐ I will provide my own list ☐ I consent to have my medication list electronically obtained from my pharmacy

Do you have any drug allergies? ☐ Yes ☐ None known. If YES, list: ______________________________

Family History

Has any member of your family had these diseases? **(Mother, Father, Grandparent, Sibling)**

Disease Condition	Y	N	?	Relationship
Blindness	☐	☐	☐	__________
Crossed Eyes	☐	☐	☐	__________
Glaucoma	☐	☐	☐	__________
Macular Degeneration	☐	☐	☐	__________
Retinal Detach/Disease	☐	☐	☐	__________
Rheumatoid Arthritis	☐	☐	☐	__________
Prostate/ Breast Cancer	☐	☐	☐	__________
Diabetes	☐	☐	☐	__________
Heart Disease	☐	☐	☐	__________
High Blood Pressure	☐	☐	☐	__________
Kidney Disease	☐	☐	☐	__________
Lupus	☐	☐	☐	__________
Thyroid Disease	☐	☐	☐	__________
Other __________	☐	☐	☐	__________

Social History

Do you smoke or use any tobacco products? ☐Yes ☐No ☐Former Smoker

If YES, how much?: ________ For how many years?: ________

Do you consume alcoholic beverages? ☐Yes ☐No

If YES, how many drinks per day? ________

Do you drive during the day? ☐Yes ☐No

Do you drive at night? ☐Yes ☐No