



310 East Main Street Wytheville, VA 24382
P: 276.228.2771 F: 276.228.9097

NEW PATIENT FORM

Date: ____/____/____
First Name: _____ MI: ____ Last Name: _____
Address: _____ SSN: _____
City: _____ State: _____ ZIP: _____
Birth Date: ____/____/____ Male Female Home Phone: (____) _____
Email Address: _____ Cell Phone: (____) _____

Preferred contact method: Home Phone Cell Phone E-mail Voicemail Message Text Message
 Married Single Widowed Divorced Other _____ **Preferred language:** _____
Employment: Full-Time Part-Time Retired Not Employed Race: _____
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: (____) _____ Alt. 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	Y	N	?	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	_____
Retinal Detach/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate/ Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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