Gettysburg Ophthalmology Associates
455 S. Washington Street, Suite 24
Gettysburg, PA 17325
Office: (717)334-9159
Fax: (717)334-7225

Full Name: _____ Date of Birth: _____/_____/_____

Social Security Number: _____ Sex: □ Male □ Female

Home Address: _____

_____

Home Phone Number: _____

Mobile Phone Number: _____

Preferred Phone Number (please circle): HOME MOBILE

Email address: _____

Authorized to Leave a voicemail? YES NO

Preferred Pharmacy: _____

Primary Care Physician: _____

Emergency Contact: _____Phone#_____

Relationship to patient: _____

Date of last eye exam: _____

Location of last eye exam: _____

Reason for today's visit: _____

Were you referred by another physician? YES NO

If yes, which doctor: _____

Do you have any of the following **symptoms**?

Eye pain	YES	NO	Discharge	YES	NO
Blurred vision	YES	NO	Light Sensitivity	YES	NO
Eyelid Crusting	YES	NO	Double Vision	YES	NO
Flashes of light	YES	NO	Decreased Vision	YES	NO
Floaters	YES	NO	Halos/Auras	YES	NO

Please list all current medications (Prescription or over the counter):

_____
_____
_____
_____

Do you have any known **allergies** to any medications? YES NO

If yes, please list medication allergy and related symptoms:

_____
_____
_____

Do **YOU** have any of the following **eye conditions** (please circle yes or no):

Cataracts	YES	NO	Dry Eyes	YES	NO
Glaucoma	YES	NO	"Lazy" Eye	YES	NO
Macular Degeneration	YES	NO	Strabismus "eye turn"	YES	NO
Dry Eyes	YES	NO	Retinal Detachment	YES	NO
Corneal Disease	YES	NO			

Family History of eye disease or eye conditions:

Cataracts	YES	NO	Dry Eyes	YES	NO
Glaucoma	YES	NO	"Lazy" Eye	YES	NO
Macular Degeneration	YES	NO	Strabismus "eye turn"	YES	NO
Dry Eyes	YES	NO	Retinal Detachment	YES	NO
Corneal Disease	YES	NO			

Have you ever had any previous **eye** surgeries (if yes, please explain)?

_____
_____

Have you ever had any other surgeries (if yes, please explain)?

_____
_____
_____

Social:

Do you drive?	YES	NO	
Have you ever had a blood transfusion?	YES	NO	
Do you smoke?	YES	NO	if yes, how many packs per day? _____
Do you drink alcohol?	YES	NO	if yes, how many drinks per week? ____

Do **YOU** have any of the following **medical conditions**?

High Blood Pressure	YES	NO	Diabetes	YES	NO
Heart disease/conditions	YES	NO	Thyroid	YES	NO
High Cholesterol	YES	NO	Autoimmune disorders	YES	NO
Stroke	YES	NO	HIV	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Ear/Nose/Throat conditions	YES	NO	Headaches	YES	NO
Environmental/Seasonal Allergies	YES	NO	Neurological disorders	YES	NO
Kidney conditions	YES	NO	Liver Conditions	YES	NO
Uriniary Conditions	YES	NO	Bleeding disorders	YES	NO
Anxiety/Disorders	YES	NO			

Do you have a family history of any of the following medical conditions?

High blood pressure	YES	NO	Heart disease	YES	NO
High Cholesterol	YES	NO	Stroke	YES	NO
Diabetes	YES	NO	Thyroid	YES	NO
Autoimmune disorders	YES	NO	Cancer	YES	NO

Financial & HIPAA Policies

Assignment of Insurance Benefits and Release of Information:

I authorize payment directly to Gettysburg Ophthalmology Associates for any medical/surgical benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained during my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute or regulation.

Non-Covered Services:

I accept responsibility of paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Gettysburg Ophthalmology Associates and the insurance carrier. All out-of-pocket balances (co-payments, co-insurances and deductibles) are due at the time of service unless previous arrangements have been made in writing with the office. It is the Patient's/Responsible Party's duty to know what their out-of-pocket expenses will be before seeking treatment.

Payment Options:

You may pay your out-of-pocket costs at the time of service by Check, Cash or Credit Card. There is a fee of forty dollars ($40) for any check returned by your bank (for any reason).

Past Due Accounts:

If at any time you have a balance due which is more than 90 days old your account will be referred to an outside collection agency without further notice, and you hereby agree to pay for all collection costs incurred. Furthermore, you understand that if your account is submitted to a collection agency, and thereby reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record. We will also contact your insurance carrier, informing them of your failure to up-hold your agreement with them, which at their discretion, may result in termination of your policy.

Signature: _____ Date: _____/_____/_____