Patient Information

GUNDERSON eyecare

Date: _____

Personal Information

Full Name: _____ / _____ / _____
Last *First* *M.I.*

Address: _____
Street Address *Apt./Unit #*

_____

City *State* *ZIP Code*

Birth Date: _____ Social Security/Government ID: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____

Who is your employer? _____ Job title/ Grade: _____

Marital Status: (*Please Circle One)* Single Married Divorced Other

Spouse's Name: _____
Guardian/ Guardian/
Spouse's Employer: _____ Spouse's Work #: _____

Family Physician: _____

Who can we thank for referring you? _____

The following 3 questions required for Federal reporting purposes only:

Race: ___African American ___Alaskan Native ___American Indian ___Asian
___Pacific Islander ___White ___ Other

Ethnicity: ___Hispanic or Latino Origin ___Not of Hispanic or Latino Origin

Language: ___Chinese ___English ___Korean ___Other ___Spanish
___Tagalog ___Vietnamese

Insurance Policy Holder Information

Last name_____ First name_____ MI____

Birthday ____/____/_____ Social Security Number: _____

Employer: _____

Secondary

Last name_____ First name_____ MI____

Birthday ____/____/_____ Social Security Number: _____

Employer: _____

I give Gunderson Eyecare permission to bill my insurance company and to release any pertinent information that is needed to process my claim.

_____ Date _____

How do you use your eyes?

Please answer the following questions to help our eye care team provide you with the best vision possible.

1. Do you wear contact lenses? Yes or No

   If No, would you be interested in wearing contact lenses? Yes or No

   If Yes, do your current contacts provide good comfort and vision? Yes or No

2. How many pairs of glasses do you use? _____

3. I am interested in learning more about the following: (check all that apply)
   - ○ Polarized lenses or Prescription Sunglasses
   - ○ Computer lenses
   - ○ Sports Eyewear
   - ○ Non-glare lenses
   - ○ Changeable tinted lenses (change from light to dark and back)
   - ○ Other _____

Release of Medical Information

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Children: _____

[ ] Parents: _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

Messages: *Please Check Your Preferred form of Communication*

Please call: [ ] my home [ ] my work [ ] my cell number: [ ] Call **OR** [ ] Text
[ ] Email

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ___/ ___/ ___

Witness: _____ Date: ___/ ____/ ___

Gunderson Eyecare P.C.
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