MICHAEL GETTELFINGER, OD, FAAO
PATIENT INFORMATION AND MEDICAL HISTORY

Name_____Date of Birth_____Gender____ Today's Date_____

Address_____City_____State_____Zip_____

Telephone: Hm_____Wk_____Cell_____

Race_____ Ethnicity_____ Preferred Language_____ Occupation_____

Emergency Contact: _____Telephone:_____

Circle your preferred method of Communication with us: home phone cell phone e-mail no preference

When you are due to come in again, please circle how you would like your reminder sent to you: postcard e-mail

E-mail_____

Name of person(s) you authorize to talk to us about your health information: _____

_____

Personal Health History: *Please circle conditions you have:*

Diabetes – Type_____ Diabetic Doctor Name_____

High Blood Pressure High Cholesterol Pain Arthritis Anxiety /Depression Allergies

Other_____

Medicine(s) you're taking:_____

Medicine(s) you're allergic to:_____

Other Allergies?_____ Do you use: Tobacco / Cigarettes

Personal Eye Information: *Please circle conditions you have:*

Glaucoma Cataract Retinal/Macular Floaters Dry Eye Blur Discomfort Headache

Other: _____

Do you wear: Glasses: Yes No Contact Lenses: Yes No If yes, are you wearing contacts today? Yes No

Have you had any Eye operations? _____Date_____Eye injury?_____Date_____

Insurance:
Dr. Gettelfinger accepts many insurance plans. We will assist you in determining your eligibility and benefits, but you are ultimately responsible for knowing your insurance coverage.

Routine Vision Insurance_____Medical Insurance_____

I authorize the release of the medical information necessary to submit claims to my insurance company and payment of benefits from my insurance company to Dr. Michael Gettelfinger. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Relationship to Patient_____Date_____