Office of J.E. Gundersheimer, O.D.

Patient Information

Please note: ***These questions are necessary for the proper transmission of your health data to the insurance Global Portal. This process is being mandated by Medicare and insurance to allow our office to send and receive information about you to other healthcare providers and to yourself, as well. This information will be treated with the utmost care and privacy on our part (please read and sign our Notice of Privacy Practices), but it is extremely important for you to answer every question on this form as completely and accurately as you can. Failure to do so may jeopardize our ability to file for or collect insurance payments for you in a timely manner. We appreciate your patience and cooperation in this matter; this information is standard practice in all medical professions now.***

Date:___/___/_____ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐
First Name:_____ MI:____ Last Name: _____
Nickname or Preferred Name:_____
Mailing Address:_____City:_____ST:___Zip:_____
Home Phone:____-____-_____Cell Phone:____-____-_____Work Phone:____-____-
_____
Date of Birth:___/___/_____ Sex: M ☐ F ☐ Social Security Number:_____-____-_____
e-Mail Address (*to send you your exam results*):_____@_____
_____.____
Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor ☐

Demographic information:
Race/Ethnicity: White ☐ Black or African American ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Two or more ☐ Other ☐

	English	Non-English	Unknown	Declined
Spoken language preferred:	☐	☐	☐	☐

Emergency Contact:_____Relationship:_____
Emergency Contact Number:____-____-_____
Primary Physician:_____ Phone:_____-_____-_____

Employment Information:
Name of Employer/Company:_____
Address:_____
Phone Number:____-____-_____ Occupation:_____ Number of Years:_____
Worker's Comp Claim: Y ☐ N ☐ If yes, Supervisor's name/HR contact:_____
_____

Whom may we thank for referring you to our office?
Friend ☐ Family Member ☐ Physician ☐ Insurance ☐ Internet ☐ Phone Book ☐ Other ☐
Name of referral source:_____ Phone Number:_____-_____-_____

Full-time Student? Y ☐ N ☐ Current Grade:_____ Name of School:_____

If college, what is your major?_____

Office of J. E. Gundersheimer, O. D.
Insurance Information

Patient Name:_____ Date:____/_____/_____

Guarantor Information (If other than Self):
First Name:_____ MI:_____Last Name:_____
Date of Birth:___/___/_____ Social Security Number:____-____-_____ Sex: M ☐ F ☐
Address: Same ☐ Other:_____
Phone Number: Same ☐ Other: _____-_____-_____ Relationship:_____

Medical Insurance Information:
Insured's First Name: Same ☐_____ MI:____ Last Name:_____
Insurance Company Name:_____
Insured's ID Number: _____
Patient's ID Number (If noted on card):_____
Group Number:_____

Vision Insurance Information:
Insured's First Name: Same ☐_____ MI:____ Last Name:_____
_____
Insurance Company Name:_____
Insured's ID Number: _____
Patient's ID Number (If noted as different on card):_____
Group Number:_____

Secondary Medical Insurance Information:
Insured's First Name: Same ☐_____ MI:____ Last Name:_____
Insurance Company Name:_____
Insured's ID Number: _____
Patient's ID Number (If noted on card):_____
Group Number:_____

The patient's portion is due at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient (or guarantor). The undersigned will ultimately be responsible for any bill incurred by this office regardless of insurance. There will be a $25 service charge assessed on all returned checks.

Payment from my insurance is to be paid directly to J. E. Gundersheimer, O. D. I understand that the above primary insurance company will be billed on my behalf. ***I understand that all benefits quoted to me***

are not a guarantee of payment by my insurance company and that final determination can only be made after the claim is processed.

My signature below includes acknowledgement of the *Notice of Privacy Practices* of Jerome E. Gundersheimer, O. D.

Signature:_____ **Date:** ____/____/____

Office of J. E. Gundersheimer, O. D.
Patient Health History

Name:_____ Date:____/____/____

What is the reason for your visit today?_____

How long has this been bothering you/going on?_____
When was your least eye exam?_____ Last medical exam?_____
Was a blood workup done then? Y ☐ N ☐ If so, normal? Y ☐ N ☐ Describe any abnormal results:

Allergies: (What are you allergic to?) (Describe response, e.g. hives, difficulty breathing, etc.)
Medications:

Other:

Medications: (A copy of a current list is acceptable, provided it contains the following information)

Ocular (For eyes): Drops/Pill/Oint/Injtn	Strength	Frequency	

Systemic (All Others, Including Over-the-Counter Supplements):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History: System/Condition	Check ONLY if Applies	Year (or Current)	Family History YES	Relationship
General/Constitutional				
Pregnant	☐			
Weight Loss or Gain	☐	_____	☐	_____
Frequent Thirst	☐	_____	☐	_____
Fevers or Chills	☐	_____	☐	_____
Insomnia	☐	_____	☐	_____
Fatigue	☐	_____	☐	_____
Other_____	☐	_____	☐	_____

Ears/Nose/Mouth/Throat				
Dizziness	☐	_____	☐	_____
Decreased Hearing/Deafness	☐	_____	☐	_____
Sinus Congestion	☐	_____	☐	_____
Sore Throat	☐	_____	☐	_____
Dry Mouth	☐	_____	☐	_____
Hoarseness	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Cardiovascular				
High Blood Pressure	☐	_____	☐	_____
Low Blood Pressure	☐	_____	☐	_____
Heart Attack	☐	_____	☐	_____
Stroke	☐	_____	☐	_____
High Cholesterol	☐	_____	☐	_____
Congestive Heart Failure	☐	_____	☐	_____
Irregular Heartbeat	☐	_____	☐	_____
Heart Murmur	☐	_____	☐	_____
Stint/Bypass	☐	_____	☐	_____
Pacemaker	☐	_____	☐	_____
Aneurism	☐	_____	☐	_____
Chest Pain (Angina)	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Respiratory				
Asthma	☐	_____	☐	_____
Emphysema	☐	_____	☐	_____
COPD	☐	_____	☐	_____
Lung Cancer	☐	_____	☐	_____
Tuberculosis	☐	_____	☐	_____
Pneumonia	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Gastrointestinal				
GERD	☐	_____	☐	_____
Hepatitis/Jaundice	☐	_____	☐	_____
Crohn's Disease	☐	_____	☐	_____
Diverticulitis	☐	_____	☐	_____
Constipation	☐	_____	☐	_____
Colon polyps/Cancer	☐	_____	☐	_____

Abdominal Pain/Nausea	☐	_____	☐	_____
Gallstones/G B Removed	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Genitourinary				
Menopause	☐	_____	☐	_____
Frequent Urination	☐	_____	☐	_____
After Bedtime Urination	☐	_____	☐	_____
Blood in Urine	☐	_____	☐	_____
Kidney Stones	☐	_____	☐	_____
Dialysis	☐	_____	☐	_____
Incontinence	☐	_____	☐	_____
Cancer	☐	_____	☐	_____
STD	☐	_____	☐	_____
Other_____	☐	_____	☐	_____

Musculoskeletal				
Osteo Arthritis	☐	_____	☐	_____
Rheumatoid Arthritis	☐	_____	☐	_____
Fibromyalgia	☐	_____	☐	_____
Joint pain or stiffness	☐	_____	☐	_____
TMJ	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Integumentary (Skin)				
Psoriasis	☐	_____	☐	_____
Eczema	☐	_____	☐	_____
Seborrhea	☐	_____	☐	_____
Acne/Rosacea	☐	_____	☐	_____
Shingles	☐	_____	☐	_____
Frequent Cold Sores	☐	_____	☐	_____
Skin Cancer	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Neurological				
Multiple Sclerosis	☐	_____	☐	_____
Parkinson's Disease	☐	_____	☐	_____
Alzheimer's Disease	☐	_____	☐	_____
Brain/Spinal Cord Cancer	☐	_____	☐	_____
Epilepsy	☐	_____	☐	_____
Vertigo	☐	_____	☐	_____
Migraines/Migraine Auras	☐	_____	☐	_____
Headaches	☐	_____	☐	_____
Fainting	☐	_____	☐	_____
Paralysis	☐	_____	☐	_____
Numbness/Tingling/Weakness	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Psychiatric				
Memory Loss	☐	_____	☐	_____
Depression	☐	_____	☐	_____
Alzheimer's	☐	_____	☐	_____
Dementia	☐	_____	☐	_____
Schizophrenia	☐	_____	☐	_____
Eating Disorder	☐	_____	☐	_____

Claustrophobia	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Endocrine				
Type 2 Diabetes	☐	_____	☐	_____
Type 1 Diabetes	☐	_____	☐	_____
Hypothyroid	☐	_____	☐	_____
Hyperthyroid Grave's Disease)	☐	_____	☐	_____
Other_____	☐	_____	☐	_____
Lymphatic/Hematologic				
Anemia	☐	_____	☐	_____
Sickle Cell Anemia	☐	_____	☐	_____
Leukemia	☐	_____	☐	_____
HIV	☐	_____	☐	_____
Polycythemia	☐	_____	☐	_____
Bleeding Problems	☐	_____	☐	_____
Lyme Disease	☐	_____	☐	_____
Other_____	☐	_____	☐	_____

Allergic/Other Immunologic				
Hayfever	☐	_____	☐	_____
Lupus	☐	_____	☐	_____
Sjörgren's Syndrome	☐	_____	☐	_____
Other Autoimmune Disease	☐	_____	☐	_____

Prior Surgeries:

Ocular (Eye):	Right Eye	Left Eye	Both Eyes	Year	Doctor
Cataract	☐	☐	☐	_____	_____
After-Cataract (Laser)	☐	☐	☐	_____	_____
Glaucoma	☐	☐	☐	_____	_____
Retinal Detachment	☐	☐	☐	_____	_____
Diabetic Laser	☐	☐	☐	_____	_____
Strabismus (Muscles)	☐	☐	☐	_____	_____
Retinal Laser for Hole	☐	☐	☐	_____	_____
Membrane Peel	☐	☐	☐	_____	_____
LASIK/PRK/RK	☐	☐	☐	_____	_____
Cornea Transplant	☐	☐	☐	_____	_____
Tumor Removal	☐	☐	☐	_____	_____
Enucleation	☐	☐	☐	_____	_____
Surgery to Orbit, Sinus	☐	☐	☐	_____	_____
Other_____	☐	☐	☐	_____	_____

_____

Other Surgeries:

Type of surgery	Year	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Computer Demands:

Computer Use? Y ☐ N☐ Hours/Day: 1-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 10+ ☐_
Constant w/out Breaks ☐ Constant w/ Breaks ☐ Limited ☐ Variable ☐
Work ☐ Home ☐ Both ☐ Arm's length from monitor ☐ Inside arm's length from monitor ☐

Sports (Check all that apply):
Football ☐ Baseball ☐ Basketball ☐ Softball ☐ Track/Running ☐ Volleyball ☐ Tennis ☐ Golf ☐
Cycling ☐ Fishing/Boating ☐ Snowskiing ☐ Swimming ☐ Soccer ☐ Working Out/Lifting Weights ☐
Other_____☐

Hobbies (Check all that apply):
Knitting/Sewing ☐ Drawing/Painting/Sculpting ☐ Reading ☐ Crosswords ☐ Video Gaming ☐ Carpentry ☐
Gardening ☐ Photography ☐ Music ☐ Stamp/Coin Collecting ☐ Showing/Raising Animals ☐
Other_____ ☐

Thank you for taking your time to provide us this information!! It helps us do a better job of meeting your vision needs and taking the best care of your eyes that we can!!