



519 North Mills Avenue | Orlando | 32803
407.447.7739 | www.eolaeyes.com

PERSONAL INFORMATION

Patient Name: _____ Salutation: Mr. Ms. Mrs. Dr. Rev.
 Parent/Guardian (if child): _____ Male Female
 Address: _____ Date of Birth: ____ / ____ / ____
 City: _____ ST: _____ Zip: _____ Home Phone: _____
 Occupation/Hobbies: _____ Work/Cell Phone: _____
 How did you find out about us? _____ Email: _____

PERSONAL HEALTH HISTORY

Reason for today's visit: _____ Last eye exam: _____
 Do you wear glasses? YES NO Contact lenses? YES NO Are you interested in contact lenses? YES NO

Do you have any of the following eye-related problems? (PLEASE CIRCLE)

- | | | |
|------------------|-----------------------|--------------------------|
| BLURRY VISION | EYESTRAIN / HEADACHES | EYE ITCHING / IRRITATION |
| SPOTS / FLOATERS | FLASHES OF LIGHT | HISTORY OF EYE INJURY |
| DRY EYES | DOUBLE VISION | HISTORY OF EYE SURGERY |

Do you have high blood pressure? YES NO Do you have diabetes? YES NO

Do you have any problems with any of these systems? (PLEASE CIRCLE)

- | | | | |
|----------------|--------------------|------------------|-------------------|
| CARDIOVASCULAR | ENDOCRINE (GLANDS) | ALLERGIC/IMMUNE | EAR/NOSE/THROAT |
| RESPIRATORY | BLOOD/LYMPH | GASTROINTESTINAL | MUSCULOSKELETAL |
| NERVOUS | MENTAL | GENITOURINARY | INTEGUMENT (SKIN) |

List any medications you take: _____

List any allergies you have to medicines: _____

Do you use any of the following? (PLEASE CIRCLE) Cigarettes/Tobacco Alcohol Social drugs

FAMILY HEALTH HISTORY

Have any of your blood relatives had any of the following conditions? (PLEASE CIRCLE)

- | | | |
|----------|---------------------|--------------------------|
| GLAUCOMA | CATARACTS | MACULAR DEGENERATION |
| LAZY EYE | RETINAL DETACHMENT | OTHER EYE DISEASE: _____ |
| DIABETES | HIGH BLOOD PRESSURE | HEART DISEASE / STROKE |

VISION INSURANCE INFORMATION • PLEASE READ & SIGN

Do you have vision insurance? YES NO If so, name of vision insurance plan: _____

Member Name: _____ Member Social Security No.: _____

Patient's Relationship to Insured/Member (PLEASE CIRCLE): SELF SPOUSE CHILD OTHER: _____

Please sign to authorize the release of any medical or other information necessary to process your insurance claims & to authorize the payment of medical benefits to Drs. Giedd and Williams for services you receive.

Signature: _____

Dr.'s Initials:
Date:

Please note that some procedures necessary to diagnose and treat eye health conditions may not be covered by your vision insurance.



Receipt of Notice of Privacy Practices

**I, _____, have reviewed a copy of the Eola Eyes
Notice of Privacy Practices.**

Authorized Signature _____ Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so, as documented below.

Date _____ Initials _____ Reason: _____