Dr. Dennis J. Guerrieri, OD

NEW PATIENT WELCOME SHEET

Patient's Name (Last) _____ (First) _____

Phone _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Email Address _____ SSN _____

We currently use an automated system to send you text messages, emails and voice recordings for appointment reminders and notifications about glasses and contact lenses. **Check this box if you prefer to not to use this system:** ☐

Occupation _____ Employer _____

Hobbies _____

Emergency Contact Name / Phone _____

How did you hear about us? _____

Are we using vision insurance for your visit? ☐ **YES** ☐**NO**

If you checked **YES**, who is the responsible party for billing any insurance copays, overages or non-covered services? ☐ **SELF** ☐**SPOUSE** ☐**PARENT**

If you checked **SPOUSE** or **PARENT**, please provide their contact information:

Name (Last) _____ (First) _____

Address _____

Phone _____ Date of Birth _____

SSN or Member ID Number _____

Date of last eye exam _____ Date of last medical exam _____

Do you have allergies (environmental, drug, etc.)? ☐**NO** ☐ **YES** If **YES**, explain: _____

_____

List all medications (with dosages) _____

_____

Do you use tobacco products? ☐**NO** ☐ **YES** If **YES**, type/amount/how long? _____

Do you drink alcohol? ☐**NO** ☐ **YES** If **YES**, type/amount/how long? _____

Do you use illegal drugs? ☐**NO** ☐ **YES** If **YES**, type/amount/how long? _____

This information is kept strictly confidential. However, check here if you prefer to discuss your social history directly with the doctor ☐

Continued on Reverse

Note any family history *[parents, grandparents, siblings, children (living or deceased)]* and indicate *maternal* or *paternal*.

Blindness	□ **YES**	□ **NO**	Relationship: _____
Cataract	□ **YES**	□ **NO**	Relationship: _____
Crossed Eyes	□ **YES**	□ **NO**	Relationship: _____
Diabetes	□ **YES**	□ **NO**	Relationship: _____
Detached Retina	□ **YES**	□ **NO**	Relationship: _____
Glaucoma	□ **YES**	□ **NO**	Relationship: _____
Heart Disease	□ **YES**	□ **NO**	Relationship: _____
High Blood Pressure	□ **YES**	□ **NO**	Relationship: _____
Macular Degeneration	□ **YES**	□ **NO**	Relationship: _____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injuries, refractive surgeries (such as LASIK) _____

_____

Do you currently have, or have you ever had, any problems in the following areas? *Please circle all that apply:*

Eyes

Blurred Vision
Halos
Peripheral Vision Loss
Double Vision
Dryness
Mucous Discharge
Redness
Itching
Excess Tearing
Glare/Light Sensitivity
Eye Pain/Soreness
Flashes/Floaters
Tired Eyes

Bones, Joints, Muscles

Rheumatoid Arthritis
Muscle Pain
joint Pain

Neurological

Headaches
Migraines
Seizures

Psychiatric

Anxiety
Depression
Memory Trouble

Ears, Nose, Mouth, Throat

Allergies
Sinus Congestion
Runny Nose
Dry Throat/Mouth

Respiratory

Asthma
Emphysema

Lymphatic/Hematologic

Anemia

If you circled any of the above, or have a condition not listed, please explain: _____

_____

_____

I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me to obtain payment of my insurance benefits.

Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Print Name _____ Relationship to Patient _____