TODD, GIANNETTI & RALSTON
Eye Care

Patient Information:

Last Name: First Name: M.I. Preferred Name:

Mailing Address: Apt #

City: State: Zip:

Home Phone: Cell Phone: Work Phone/Ext.

Email:

Preferred Method of Contact: ☐ Phone Call ☐ Text

If Phone Call Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Date of Birth: Social Security #: Gender:

Marital Status:
☐ Single ☐ Married ☐ Single ☐ Other _____

Family Physician: Location: Phone #:

Pharmacy: Location: Phone #:

Last Eye Exam: Last Eye Dr: ☐ Glasses ☐ Contacts

How Old Are Your Current Glasses: Contact Lens Brand:

Emergency Contact: Phone #: Relationship:

Employer/School: Occupation: Hobbies:

Name of Other Family Members Seen in Our Office:

Referred By:

Responsible Party – If the patient is a minor, the parent or guardian bringing in the patient will be listed as the guarantor:

Last Name: First Name: M.I. Preferred Name:

Mailing Address: Apt #

City: State: Zip:

Home Phone: Cell Phone: Work Phone/Ext.

Date of Birth: Social Security #: Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Race (please select):

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Decline

Ethnicity (please select one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other

Primary Medical Insurance:	**Secondary Medical Information:**
Ins. Co. Name:	Ins. Co. Name:
ID#:	ID#:
Group#:	Group#:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Policy Holder Address:	Policy Holder Address:
Policy Holder Phone #:	Policy Holder Phone#:
Relationship to Patient:	Relationship to Patient

Vision Insurance:

Ins. Co. Name:	ID#:	Group#:
Policy Holder Name:		Policy Holder Date of Birth:
Policy Holder Address:		
Policy Holder Phone #:	Relationship to Patient:	

Medical History (Please report any history of problems in the following areas.)

	Yes	No	Family		Yes	No	Family
Unexplained Weight Change	☐	☐	☐	Any Genitourinary	☐	☐	☐
Cancer (Type)	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Glaucoma	☐	☐	☐	Fibromyalgia	☐	☐	☐
Macular Degeneration	☐	☐	☐	Osteoarthritis	☐	☐	☐
Cataracts	☐	☐	☐	Muscular Dystrophy	☐	☐	☐
Allergies/Hay Fever	☐	☐	☐	Headaches	☐	☐	☐
Sinus Congestion	☐	☐	☐	Migraines	☐	☐	☐
Dizziness	☐	☐	☐	Seizures	☐	☐	☐
Heart Pain	☐	☐	☐	Depression/Anxiety	☐	☐	☐
High Blood Pressure	☐	☐	☐	Thyroid Disorders	☐	☐	☐
Stroke	☐	☐	☐	Diabetes	☐	☐	☐
Heart Attack	☐	☐	☐	Anemia	☐	☐	☐
High Cholesterol	☐	☐	☐	Bleeding Problems	☐	☐	☐
Asthma	☐	☐	☐	Aids/HIV	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	Any Gastrointestinal	☐	☐	☐
Emphysema	☐	☐	☐	Double Vision	☐	☐	☐

Are you pregnant? ☐ Yes ☐ No Due Date: Do you use tobacco/nicotine products? ☐ Yes ☐ No How much:

Have you had eye surgery? ☐ Yes ☐ No What kind? When?

Drug Allergies:

Current Medications:

Name	Dosage

I acknowledge that I have received a copy of the Notice of Privacy Practice and a copy of my rights regarding electronic health information exchange, for the office of Todd, Giannetti & Ralston EyeCare.

I agree to permit Todd, Giannetti & Ralston EyeCare and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. Mike Todd, Dr. Jace Giannetti & Dr. Ashley Ralston for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized insurance benefits to be made on my behalf to Todd, Giannetti & Ralston EyeCare for any services furnished to me. I authorize release of any medical information concerning me to your company and its agents any information needed to determine these benefits or benefits payable for related services. I also agree to pay this bill in full for any uncovered services by my insurance company.

Emergency Contact: _____ **Phone:** _____

I am authorizing the personnel at Todd, Giannetti & Ralston EyeCare to leave medical information and test results with others if I am not available. Please be advised that we cannot speak with anyone that is not listed on this form. This includes spouses, children, and caregivers.

☐ Spouse _____ ☐ Son _____

☐ Daughter _____ ☐ Other _____

☐ **I reviewed a copy of Todd, Giannetti & Ralston EyeCare's Privacy Notice** _____ **(Initials)**

Printed Name of Responsible Party: _____ **Date:** _____

Signature of Responsible Party: _____ **Date:** _____