WELCOME TO OUR OFFICE

Dr. Jesse Gibson

PLEASE PRINT!!!

Patient's Name Male Female ______________________________ **Date** __________

(First) (Middle) (Last)

Date of Birth __________ **Age** ______ **Home Phone** __________ **Work Phone** __________

Address ______________________ **City** ______________ **Zip** ________

Occupation ______________________ **Employer** ______________________

Whom may we thank for referring you to our office? ______________ Email (private use): __________

Today's doctor fee (circle): 1) Cash 3) Debit Card

2) Charge 4) Other (list) ______________

What briefly is the main reason(s) for today's visit? ______________________

Last eye exam was ____ years ago. Present prescription in glasses is ____ years old. Last doctor's name ______

Please List:

1) Any eye injuries, diseases, infections, surgeries, lazy eye, eye abnormality, that you have had:

2) Any eye diseases in your family (state what and whom):

3) Any health problems or conditions (state what & list medications):

4) Any medication allergies (list name of drug(s):

5) Any medical problems in your family (state what & whom):

6) *Females only:* Are you pregnant? yes / no / uncertain *(please circle one)*

Dilation is required in the state of Florida. Dilation consists of using eyedrops to enlarge the pupils for better observation. Vision will be blurry for 3-4 hours and an increase in light sensitivity will be experienced. Precaution should be taken when driving.

- ☐ **YES, I would like to be dilated today.**
- ☐ **NO, I will schedule for dilation another time.**

Notice of Privacy Practise

The new HIPAA law protects you against the unauthorized use of your personal medical files. Dr. gibson's Privacy Policy is located on the wall behind the reception desk. copies are available by asking. I have been shown and notified of this privacy policy.

		Circle one		
Do you use	a) Alcohol	y / n	How much? ________	Patient's Signature ______________
	b) Tobacco	y / n	How much? ________	
	c) Substances	y / n	How much? ________	Doctor's Signature ______________