CENTRAL FLORIDA EYE CENTER, P.A.
KENNETH GATSON, O.D. ◆ KRISTINE VERKAIK, O.D.
Board Certified Optometric Physicians
WELCOME TO THE OFFICE - ACQUAINTANCE FORM

Personal Information

Name _____ Today's Date ___ / _____ / _____
If Youth, Parents' Name _____
Address _____City_____State _____ZIP _____
Birth Date ____ / ____ / _____ Social Security # _____ - ____ - _____ Sex ❑ M ❑ F
Preferred language _____ Race _____ Ethnicity: 1.)American 2.) Other_____
Height_____ Weight _____ Preferred method of communication telephone other____
Marital Status _____Occupation_____
Primary Phone# _____Cell Ph#_____E-Mail_____
May we thank someone for referring you to us? _____

Ocular History

Have you had any eye surgery, injury or disease? ❑ No ❑ Yes If yes, please explain:
_____
Date of last eye exam _____ By whom? _____
Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your present pair of lenses? _____

Have your eyes recently given you any of the following symptoms? ❑ Check here if ***NO*** to all

	No	Yes		No	Yes
Itching	❑	❑	Double Vision	❑	❑
Burning	❑	❑	Distorted Vision	❑	❑
Dryness	❑	❑	Foreign Body Sensation	❑	❑
Redness	❑	❑	Excess Tearing/Watering	❑	❑
Blurred Vision	❑	❑	Glare/Light Sensitivity	❑	❑
Twitching	❑	❑	Eye Pain or Soreness	❑	❑
Mucous Discharge	❑	❑	Chronic Infection of Eye or Lid	❑	❑
Loss of Vision	❑	❑	Sties	❑	❑
Sandy or Gritty Feeling	❑	❑	Flashes/Floaters in Vision	❑	❑

Family and Social History

Has a parent or sibling had blindness, lazy eye, glaucoma or eye disorder? ❑ No ❑ Yes
Explain _____

Do you use tobacco products? ❑ No ❑ Yes
❑Everyday (heavy) ❑Somedays (light) Former Smoker? ❑ No ❑ Yes
Do you drink alcohol? ❑ No ❑ Yes If yes, do you drink more than 2 drinks daily? ❑ No ❑ Yes
Do you use any other substances? ❑ No ❑ Yes If yes, type/amount/how long? _____

Medical History

Name of Medical Doctor _____ Last Medical Exam ___ / ___ / _____
Please list all medicines you are presently taking (Check here if you take no medicines ❒)_____
_____
_____

**Please turn this form over and complete the other side **

Review of Systems

Do you have any problems in the following Systems? (If yes, please explain) ❑ Check here if ***NO***

SYSTEM	NO	YES	EXPLAIN
ALLERGY. Do you have an allergy?	❑	❑	List medicines or allergens you are allergic to:
			_____
			_____
			_____
CARDIOVASCULAR	❑	❑	_____
High Blood Pressure	❑	❑	_____
Vascular Disease	❑	❑	_____
CONSTITIUTIONAL (fever, weight loss)	❑	❑	_____
ENDOCRINE	❑	❑	_____
Do you have diabetes?	❑	❑	Years since diagnosed ____Blood sugar_____ A1C___
Diabetes Treatment. Circle one:			oral medicine insulin diet
Thyroid disorder	❑	❑	_____
GASTROINTESTINAL	❑	❑	_____
Diarrhea	❑	❑	_____
Constipation	❑	❑	_____
GENITOURINARY (genitals/kidney/bladder)	❑	❑	_____
EARS, NOSE, MOUTH THROAT	❑	❑	_____
Sinus Congestion	❑	❑	_____
Chronic Cough	❑	❑	_____
Dry Throat/Mouth	❑	❑	_____
HEMATOLOGIC/LYMPHATIC	❑	❑	_____
Anemia	❑	❑	_____
Bleeding Problems	❑	❑	_____
IMMUNOLOGIC	❑	❑	_____
HIV Positive	❑	❑	_____
Sjogrens Syndrome	❑	❑	_____
INTEGUMENTARY (skin)	❑	❑	_____
MUSCULOSKELETAL	❑	❑	_____
Arthritis	❑	❑	_____
Myasthenia Gravis	❑	❑	_____
NEUROLOGICAL	❑	❑	_____
Headaches	❑	❑	_____
Horners Syndrome	❑	❑	_____
Multiple Sclerosis	❑	❑	_____
PSYCHIATRIC	❑	❑	_____
RESPIRATORY	❑	❑	_____
Asthma	❑	❑	_____
COPD	❑	❑	_____

Insurance Information

If you would like us to submit an insurance claim for you, list each insurance and sign lifetime authorization: I request that payment of authorized insurance benefits be made on my behalf to Central Florida Eye Center, P.A. I authorize Dr. Gatson/Verkaik to release information about me to the insurance company and its agents to determine benefits for related services.

Name of Insurance Company	ID #	Patient lifetime authorization signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

Notice of our Privacy Practices (Please take a copy of attached "Notice of Privacy Practices")

I acknowledge that I received a copy of Dr. Gatson/Verkaik "Notice of Privacy Practices"_____

(Please Initial)