

CENTRAL FLORIDA EYE CENTER, P.A.
 KENNETH GATSON, O.D. ♦ KRISTINE VERKAIK, O.D.
 Board Certified Optometric Physicians

Personal Information

Name _____ Today's Date ____ / ____ / ____
 Check here if no changes to personal information
 Address _____
 City _____ State _____ Zip _____
 Occupation _____ Marital Status _____
 Primary Contact phone # _____ Cell Ph# _____ E-Mail _____
 Date of Birth ____ / ____ / ____

Ocular History

Have you had any eye injury or disease since your last visit to our office?
 No
 Yes. Please explain: _____

Since your last visit to our office, have your eyes given you a problem in any of the following areas?
 Check here if **NO** to all

	No	Yes		No	Yes
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>
Twitching	<input type="checkbox"/>	<input type="checkbox"/>			

Family and Social History

Has a parent or sibling had blindness, lazy eye, glaucoma or eye disorder? No Yes Explain _____ Have there been any changes in your medical, family, or social history since you filled out your last acquaintance form in our office on ____ / ____ / ____ ?
 No
 Yes, if yes please explain: _____

Do you use tobacco products? No Yes Everyday (heavy) Somedays (light) Former Smoker? No Yes

Do you have diabetes? No Yes Years since diagnosed _____ Blood sugar _____ A1C _____
 Diabetes Treatment. Circle one: oral medicine insulin diet

What medicines are you presently taking? (Check here if not taking any medicine)

Are you allergic to any medicines? No Yes _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

