CENTRAL FLORIDA EYE CENTER, P.A.
KENNETH GATSON, O.D. ◆ KRISTINE VERKAIK, O.D. ◆ ROBYN GLASS, O.D◆LORI MILLS HELMAN, 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	❑	❑	________
OTHER	❑	❑	________

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/ Dr.Verkaik/Dr. Glass/Helman to release information about me to the insurance company and its agents to determine benefits for related services.

Name of Insurance Company

____
____
____

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/Glass/Helman "Notice of Privacy Practices"________
(Please Initial)