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

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	❑	❑	Itching	❑	❑
Blurred Vision	❑	❑	Burning	❑	❑
Distorted Vision/Halos	❑	❑	Foreign Body Sensation	❑	❑
Loss of Side Vision	❑	❑	Excess Tearing/Watering	❑	❑
Double Vision	❑	❑	Glare/Light Sensitivity	❑	❑
Dryness	❑	❑	Eye Pain or Soreness	❑	❑
Mucous Discharge	❑	❑	Chronic Infection of Eye or Lid	❑	❑
Redness	❑	❑	Sties or Chalazion	❑	❑
Sandy or Gritty Feeling	❑	❑	Flashes/Floaters in Vision	❑	❑
Twitching	❑	❑			

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
Name of Primary Care Physician: _____
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/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
_____	_____
_____	_____
_____	_____