Gailey Eye Clinic

Dear Patient:

Thank you for selecting the Gailey Eye Clinic for your vision care. To speed the registration process, please complete the other side of this form and return it prior to your visit in the envelope provided. If time does not permit you to return the questionnaire, please bring it with you on the day of your visit.

The enclosed booklet will acquaint you with Gailey Eye Clinic and the exam process. Please take a few minutes to read it before your appointment.

YOUR APPOINTMENT HAS BEEN SCHEDULED AS FOLLOWS:

Dr. _____ on _____

At _____ in the _____ clinic.

It is the patient's responsibility to verify benefits with your insurance carrier prior to your exam. Gailey Eye Clinic is not responsible for out-of-network costs or balances due after insurance has been billed. Any remaining account balance will be billed to the patient.

Dilating drops may be used at your exam. These drops allow the doctor to see inside your eye, which is the only way to accomplish a complete eye exam. These dilating drops affect people differently and on rare occasions may temporarily blur vision and increase sensitivity to bright lights. Also, some people have difficulty driving immediately after the exam. Your doctor cannot predict the exact effect on your vision. Therefore, if you have no experience with dilating drops, you may want to make special transportation plans or bring a driver with you when you come for your exam. On sunny days, you will probably be more comfortable with sunglasses. You are encouraged to bring sunglasses with you. We can provide disposable sunglasses for you if you do not have any with you at the time of your exam.

We hope you find this information useful. Also, please feel free to let us know if you were satisfied with your visit and what improvements you would like to see. The physicians value you as a patient and are always interested in serving you better.

Please Complete Reverse Side ►

Gailey Eye Clinic

PATIENT HISTORY QUESTIONNAIRE

Patient Name _____
Last First Middle Initial

Social Security Number _____

Birth date _____ _____ _____ Age _____
Month Day Year

(Circle One)
Male Female

Address _____
Number Street

_____
City State Zip Code

Phone (_____) _____ (Home)

(_____) _____ (Work)

E-mail _____

Marital Status M _____ S _____ D _____ W_____

Ethnicity Hispanic_____ Non-Hispanic_____ Other_____

Race (Select One)
White_____ Black or African American _____ Asian_____
Native American/Eskimo_____ Multiracial_____
Native Hawaiian or Other Pacific Islander _____ Other_____

Language _____

Patient Occupation / Student _____

Employer Name / Year in School _____

Name of Emergency Contact _____

Phone # of Emergency Contact (_____) _____

Family Physician _____

Were you referred to this clinic by another doctor?

Yes _____No _____

If yes, do you wish the doctor to have a report?

Yes _____No _____

Name of referring doctor _____

Address _____

PRIMARY INSURANCE _____

Insurance Address _____

Policy Number _____

Group Number _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security Number _____

SECONDARY INSURANCE _____

Insurance Address _____

Policy Number _____

Group Number _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security Number _____