GERRY
optical company
since 1912

Name: Ms. Mrs. Mr. Dr. _____Date:_____/_____/_____

Address: _____

City: _____ State:_____ Zip:_____

Birth Date: _____/_____/_____ Social Security #:_____/_____/_____

Home Phone:_____ Work Phone:_____

Email:_____

Place of Employment:_____ Occupation:_____

If a Child, Parent's Name:_____

How did you hear about us?_____

Will your account be paid by:

Cash:_____ Check:_____ Credit Card:_____ Insurance:_____

Insurance Carrier:_____ Policy #:_____

Please Note: Payment is required when services are rendered. We accept direct payment from insurance companies that we participate with and will be happy to provide you with the necessary insurance filing copy for other insurance companies. Please allow two days added to our regular service to get authorization and assignment of benefits. If you have any questions regarding your insurance, please ask the receptionist.

Visual History

Date of Last Exam:_____/_____/_____ By Whom:_____

Do you wear glasses?_____ How old are they?_____

Do you wear contacts?_____

What Kind? Soft/Hard/Gas Perm/Ext Wear

When and by whom were you fit?_____

May we request your eye care records from your previous doctor?_____

Reason for examination:_____

- ☐Routine check-up
- ☐New frame or lenses desired
- ☐Contact lenses desired
- ☐Sun protection desired
- ☐Eyes burn
- ☐Eyes itch
- ☐Eyes water
- ☐Eyes tire when reading
- ☐Distance vision blurred
- ☐Near Vision blurred
- ☐Headaches (vision related)
- ☐Seeing spots or floaters
- ☐Double vision at distance
- ☐Double vision at near
- ☐Pain in or around the eyes
- ☐Halos around lights
- ☐Motion sickness
- ☐Decreased night vision
- ☐Flashing lights
- ☐Difficulty in school
- ☐Other_____

Please list any hobbies and work related activities that cause eye fatigue or strain:

_____

_____

Medical History

Date of last physical: _____/_____/_____

List any medications you are now taking:_____

_____

- ☐Have you ever had eye surgery?
- ☐Have you ever had an eye injury?
- ☐Cataracts
- ☐Glaucoma
- ☐Blindness
- ☐Amblyopia/Lazy Eye
- ☐Major Surgery
- ☐Are you under a physicians care?
- ☐Thyroid Problems
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Heart Problems
- ☐Kidney Problems
- ☐Sinus Problems
- ☐Oral Contraceptives
- ☐Hypoglycemia
- ☐Diabetes
- ☐Major Illness
- ☐High Cholesterol
- ☐Allergies
- ☐Hay Fever
- ☐Other_____

Does any one in your immediate family have?

- ☐Glaucoma
- ☐Cataracts
- ☐Crossed eyes
- ☐Blindness
- ☐Amblyopia/Lazy Eye
- ☐Diabetes

All Information is Confidential