First Name: _____ M.I: _____ Last Name: _____ SS#: _____

□ Male □ Female Birthdate: _____ Age: _____ Marital Status: □ Single □ Married □ Divorced □ Other

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Primary Care Physician: _____

Please check your preferred contact number.

□ Home Phone: _____ Preferred Pharmacy: _____

□ Work Phone: _____ Height: _____ Weight: _____ A1C (if applicable): _____

□ Mobile Phone: _____

Preferred Language: □ English □ Spanish □ Other _____

Employer: _____

Vision Insurance: _____

Medical Insurance: _____

Do you consider yourself to be of Hispanic or Latino origin?
□ Yes □ No □ Prefer not to answer

Which of the following best describes your **race**? *Please answer this question regardless of whether you consider yourself Hispanic.*
□ American Indian / Alaska Native □ Asian
□ Black / African American □ White
□ Native Hawaiian / Pacific Islander □ Prefer not to answer

Please provide us with your health information by checking all boxes that apply:

Allergic/Immunologic □ Drug Allergy □ Environmental Allergy □ Rheumatoid Arthritis □ Lupus □ None	**Eyes** □ Glaucoma □ Cataracts □ Macular Degeneration □ Surgery □ Blurred Vision □ Inflammatory Disorder □ Double Vision □ None	**Musculoskeletal** □ Fibromyalgia □ Muscular Dystrophy □ Osteoarthritis □ Ankylosing Spondylitis □ None	**Cardiovascular** □ Heart Disease □ High Blood Pressure □ Stroke □ Vascular Disease □ None	**Other** □ Currently Pregnant □ Currently Nursing
Gastrointestinal □ Crohn's □ Colitis □ Ulcer □ Digestive □ None	**Neurological** □ Multiple Sclerosis □ Epilepsy □ Alzheimer's □ Parkinson's □ Cerebrovascular □ None	**Constitutional** □ Developmental Disability □ Weight Loss □ Fever □ Fatigue □ Trauma □ None	**Genitourinary** □ STD, Herpes, Chlamydia □ None	**Endocrine** □ Type 1 Diabetes □ Type 2 Diabetes □ Thyroid □ Hormonal Disorder □ None
Psychiatric □ Depression □ Panic Disorder □ Schizophrenia □ None	**Ear/Nose/Mouth/Throat** □ Respiratory Tract Infection □ Ear Ache □ Runny Nose □ Sore Throat □ Ringing / Tinnitus □ None	**Blood/Lymphatic** □ Anemia □ Large Volume Blood Loss □ Leukemia □ None	**Respiratory** □ Current Smoker □ Previous Smoker □ Asthma □ Bronchitis □ Emphysema □ None	**Skin** □ Eczema □ Rosacea □ Psoriasis □ None

Please check if there is a family history of any of the following:
□ Blindness □ Cataracts □ Glaucoma □ Macular Degeneration □ Lazy Eye □ High Blood Pressure □ Stroke □ Diabetes

List your medication allergies: _____

List your medications with dosage (or provide a list for scanning): _____

_____

Certification and Assignment

I hereby authorize Drs. Gundersen and Zuker to diagnose and treat my condition as deemed medically necessary. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

If Drs. Gundersen and Zuker choose to accept assignment of my insurance benefits, I hereby assign to Drs, Gundersen and Zuker all money to which I am entitled for eye care expenses relative to the service reported, but not to exceed my indebtedness to Drs. Gundersen and Zuker. I understand that I am financially responsible to Drs. Gundersen and Zuker for all charges, regardless of insurance benefits.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative *Date*

_____ _____
Print Name of Patient, Parent, Guardian, or Personal Representative *Relationship to Patient*