WELCOME TO GALLUP VISION SOURCE
Michael G. Blake, O.D.

PATIENT INFORMATION: **This update is needed yearly. Thank you.**

Last Name_____ First Name_____ MI_____
(Please include any previous names)

Address_____City_____State____Zip_____

Home Phone: ( ) - Work: ( ) -

Cell Phone: ( ) -

Date of Birth_____-_____-_____ SS#_____-_____-_____ Spouse's Name_____

Employer_____ Occupation _____ Date of last exam_____

Gender: M / F (Please circle) Age ___ When was your last visit to our office? _____
(For glasses, repair or exam)

E-Mail Address:

@

GUARANTOR INSURANCE INFORMATION:
PLEASE GIVE MEDICAL INSURANCE CARD TO FRONT DESK ASSOCIATE. THANK YOU!
Insurance Company Name_____ Policy Holders Name_____
Policy Holders SS# _____-_____-_____ Policy Holders Date of Birth: _____
Insurance Telephone_____ Insurance ID & Group #_____
PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE

HEALTH INFORMATION:
Headaches Y / N Allergies (Seasonal) Y / N Allergies to Medications_____
High Blood Pressure Y / N Diabetes Y / N Glaucoma Y / N Cataracts Y / N
Eye Operations_____ Other_____
Current Medications_____

Do you currently wear glasses? Y / N
Do you currently wear Contact Lenses? Y / N
Do you want a Contact Lens Exam today? Y / N
Do you wish to replace your Contact Lenses? Y / N
Do you have prescription sunglasses? Y / N

FAMILY HISTORY:
High Blood Pressure Y / N Relation_____ Diabetes Y / N Relation_____
Glaucoma Y / N Relation_____ Cataracts Y / N Relation_____
Other_____

DO YOU WISH TO HAVE THE RETINAL MAP EXAM DONE TODAY? Y / N
(The Retinal Map is NOT covered under most insurances)

I ACKNOWLEDGE THAT I HAVE READ A COPY OF MICHAEL G. BLAKE, O.D.'S NOTICE OF PRIVACY PRACTICE.
SIGNATURE_____ **DATE**_____
UNDER 18 YEARS OLD PARENT MUST SIGN

PAYMENT DUE AT THE TIME OF SERVICE FOR ALL DEDUCTABLES AND/OR PROFESSIONAL FEES!