Debra S. Guthrie, M.D.

*****PLEASE PRINT CLEARLY*****

Last Name	First Name	MI	SS#	DOB	Sex	Age
Street Address	Apt No.	City	State/Zip			
Marital Status	Name of Spouse	Language/Race/Ethnicity	Home/Cell Phone			
Email	Emergency Contact & Phone	Referred to by				
Employer	Occupation	Work Phone				

INSURANCE INFORMATION

Primary Insurance Coverage	ID Number				
Guarantor	Last Name	First Name	DOB	SS#	Relationship
Secondary Insurance Coverage	ID Number				
Guarantor	Last Name	First Name	DOB	SS#	Relationship

Pharmacy Name
Pharmacy address and phone

Habits:

Alcohol: Yes/No Drinks/Day_______ Drinks/Week________

Cigarettes/tobacco: Yes/No # Of Packs/Day __________

Caffeine: Yes/No Coffee Tea Other # of 8oz cups/day__________

Nutrition:

Do you take vitamins or nutritional supplements? Yes/No if yes which ones________________________

Exercise: Type__________________________________ Minutes/days______________ days/wk_________

When was your last **Vitamin D** Level taken? _________________________________

When was the last time you had a Thyroid Function Tests? ____

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Medical History:

- ***Diabetes*** ***Yes/No*** ***For ________years*** ***Arthritis*** ***Yes/No***
- ***Asthma*** ***Yes/No*** ***For ________years*** ***Cancer*** ***Yes/No of What? __________***
- ***High Blood Pressure*** ***Yes/No*** ***For ________years*** ***Emphysema*** ***Yes/No***
- ***Glaucoma*** ***Yes/No*** ***For________ years*** ***Heart Disease*** ***Yes/No***

List any medications you are taking

____

Reactions or Allergies to medications: ____

Family History: Please circle all that apply

Diabetes ***Heart Disease*** ***Hypertension*** ***Glaucoma*** ***Cataracts*** ***Blindness***

Eye History:

Last eye exam____________________________ Have you had any surgery performed on your eyes? **Yes/No**

Do you wear glasses? Yes/No if yes, for: Distance Reading Bifocals Progressive Bifocals

Do you wear contact lens? Yes/No

Disposable Hard Multifocal

I understand that I am financially responsible for any balance. (ie deductibles, coinsurances, copays etc) I request that payment of authorized benefits be made on my behalf to Dr. Guthrie for services furnished to me by the physician. I also authorize any holder of medical information about me to be released to the Health Care Financing Administration and/or agent any information needed to determine these benefits or the benefits payable for related services. I also understand that **contact lens fitting, or re-fitting** is a **separate out of pocket charge not billable to any major medical carrier** and involves several visits until a satisfactory prescription is achieved. Refraction is the testing done to determine the optical power of the eye it is **not covered by Medicare and most insurances and therefore, results in a separate fee ($25) in addition to any copays or coinsurances that may be applicable.** I accept the refraction policy________________ or I decline the refraction policy_________________

A $35 CANCELLATION FEE WILL BE APPLIED TO MISSED OR CANCELLED APPOINTMENTS WITHOUT 24HRS IN ADVANCE NOTICE.

Patient/Guardian signature_______________________________ Date__________________________