RICHENS
EYE CENTER
Vision for Life

PATIENT INFORMATION

Date_____

Patient's Name-Last_____ First_____ Middle Initial _____
❒Single ❒Married ❒Separated ❒Widowed ❒Divorced Sex: M ❒ F ❒ Ethnicity _____
Birth date_____ Age_____ Social Security #_____-_____-_____
Mailing Address_____ City_____ State____ Zip_____
Home Phone _____Cell Phone _____

RESPONSIBLE PARTY INFORMATION

All patients PLEASE complete both sections below.

Name-Last_____First_____Middle Initial_____
Mailing Address-Street_____City_____State_____Zip_____
Social Security Number _____ - ____ - ____ Working? Y ❒ N ❒ Retired Y ❒ N ❒
Employer_____Position_____Work Phone _____
SPOUSE: Name-Last_____First_____Middle Initial_____
Social Security Number _____ - ____ - ____ Working? Y ❒ N ❒ Retired Y ❒ N ❒
Employer_____Position_____Work Phone _____

Emergency Contact, please give the name of the person we should contact in case of emergency:
Name_____ Phone_____ Relationship_____
Primary Care Doctor (*Doctor to call in case of emergency*):_____
Date of last physical exam or office visit: _____ ***How did you hear about us?***
❒ ***Physician***_____ ❒ ***Friend***_____ ❒ ***Phonebook*** ❒ ***Newspaper*** ❒ ***Other***_____

INSURANCE INFORMATION

Primary Insurance: _____ID # _____ Group _____
Subscribers Name: _____ Birth date: _____ Relationship: _____
Secondary Insurance: _____ID # _____ Group _____
Subscribers Name: _____ Birth date: _____ Relationship: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Richens Eye Center all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ _____ **Date** _____

I acknowledge that I have been offered a copy of the Notice of Privacy Practices. Initial _____ **Date**_____

I, agree to pay for all deductible, co-insurance and non-covered services. If a balance remains after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. (There will be a $28.00 fee for all returned checks.) I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account with or without suit.
PLEASE NOTE: Refraction (a necessary component of a comprehensive eye exam) is NON- COVERED service of Medicare and most traditional insurances. There is a $35.00 charge for refractions that result in a glasses/contact prescription.

Initial_____

Signature_____**Date**_____

Please Print Name _____**Relationship to Patient**_____

NAME: _____ DOB: ___/___/____ Email: _____

DATE: ____/____/____ Date of last eye exam: ____/____/____ By Dr.: _____

PRIMARY CARE PHYSICIAN: _____ _____ _____ PHARMACY: _____

How can we help you today?(Reason for your visit today): _____

Do your eyes itch, burn or sting? If "ye: if "yes" for itch rate 1-10 _____ if "yes" for burn or sting, rate 1-10 ____

Currently using glasses? ☐Yes ☐No Contacts? ☐Yes ☐No Do you drive? ☐Yes ☐No, at night? ☐Yes ☐No

List all allergies to medications: ☐ NONE or : _____ _____

All other allergies (pollens, pets, foods): ☐ NONE or : _____ _____

Have you ever taken: Flomax, Uroxatrol, Hytrin, Cardura, Proscar or Saw Palmetto? (circle any/all)

Have you had all of your adult immunizations?: Influenza Yes/No year: _____

Pneumonia Yes/No Zostavax (shingles) Yes/No Whooping Cough Booster Yes/No

List all previous surgeries (including eye surgery) along with the year: ☐ NONE

***List all medications you currently use-on reverse side (over) ⇒ ⇒ (OVER) ⇒ ⇒

Smoker? ☐No ☐Yes #pks/day? ___ # years? ___ Quit? ☐No ☐Yes When? _____

Please check any that	Yourself	Mother	Father	Siblings
Amblyopia				
Cataract				
Cataract Surgery? (YR?_____)	Eye? Right Left Both			
Diabetic Retinopathy				
Dry Eye				
Floaters				
Glaucoma				
Herpes Simplex in Eye				
Herpes Zoster (shingles) of the: eyes/face				
Keratoconus				
Macular Degeneration				
Retinal Degeneration				
Retinal Detachment				
Strabismus				
Uveitis				
Hearing Loss				
Allergy				
Arthritis (OST/other)				
Rheumatoid Arthritis				
Osteoporosis				
Lupus				
Sjogren's				
Fibromyalgia				
Asthma				
COPD/Emphysema				

	Yourself	Mother	Father	Siblings
High Blood Pressure				
High Cholesterol				
Heart Disease/Stent/MI				
Valve Repair				
Cardiac Arrythmia (A fib, etc)				
Pacemaker				
Depression				
Multiple Sclerosis				
Seizure Disorder				
Stroke				
Shingles (where: _____)				
Malignant Tumor of the Eye				
Malignant Tumor of the Brain				
Malignant Melanoma				
Cancer (type: _____)				
Diabetes Mellitus (Type 1 or 2)				
Pre-Diabetes				
Thyroid disorder				
Kidney Disease				
Hepatitis (A/B/C)				
Sickle Cell Anemia				
Sickle Cell Trait				
OTHER Conditions....				

OVER ⇒

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE DROPS, HERBAL SUPPLEMENTS, VITAMINS)

☐ No Prescription Drugs needed

☐ No Supplements being taken

Multivitamin? Yes ☐ No ☐ if "yes" Brand:____________________________

Omega 3 Supplement? Yes ☐ NO ☐ if "yes" Brand: ____________________________

Medication/Supplement	Dose	Frequency	Route	Diagnosis/Disease	Prescribing Doctor