RICHENS EYE CENTER

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 _____ Email_____

Emergency Contact, please give the name of the person we should contact in case of emergency:
Name_____ Phone_____ Relationship_____

How did you hear about us?
❒ Physician_____ ❒ Friend_____ ❒ Phonebook ❒ Newspaper ❒ Other_____

RESPONSIBLE PARTY INFORMATION

IF PATIENT IS UNDER THE AGE OF 18

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 _____

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:_____/_____/_____ DATE: _____/_____/_____

Date of last eye exam: _____By Dr.: _____

PRIMARY CARE PHYSICIAN:_____ PHARMACY:_____

Date of last physical exam or office visit:_____

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

Currently wearing glasses?□ Yes □ No Contacts?□Yes □ No Do you drive?□ Yes □ No, at night?□ Yes □ No

Do your eyes itch,burn, or sting? □ Yes □ No, rate itch 1-10____ If "yes" for burn or sting, rate 1-10_____

List Allergies to medications: □ NONE or :_____

Cigarette/Cigar smoker? □ Yes □ No #pk/day?____ # years?____ Quit? □ Yes □ No When? _____

Marijuana? □ Yes □ No Prescription/OTC? Past/Current? If current, frequency_____

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

Adult immunizations? Influenza No/Yes year:____; Pneumovax No/Yes; Zostavax (shingles) No/Yes;

Whooping Cough Booster No/Yes, year:____

*** *Please see reverse side to list all medications and previous surgeries*

Please check any of the following that apply to;	Yourself	Mother	Father	Siblings		Yourself	Mother	Father	Siblings
Am					High Blood Pressure				
Cataract					High Cholesterol				
Cataract Surgery?(YR?_____)	Eye? Right Left Both				Heart Disease/Stent/MI				
Diabetic Retinopathy					Valve Repair				
Dry Eye					Cardiac Arrythmia(A fib, ect)				
Floaters					Pacemaker				
Glaucoma									
Herpes Simplex in Eye					Depression				
Herpes Zoster (shingles) of the ey					Multiple Sclerosis				
Keratoconus					Seizure Disorder				
Macular Degeneration					Stroke				
Retinal Degeneration					Shingles (where:_____)				
Retinal Detachment									
Strabismus					Malignant Melanoma				
Uveitis					Malignant Tumor of the Brain				
					Malignant Tumor of the Eye				
					Cancer (type:_____)				
Hearing Loss									
					Diabetes Mellitus (Type 1 & 2)				
Allergy					Pre-Diabetes				
Arthritis (OST/other)					Thyroid Disorder				
Rheumatoid Arthritis					Kidney Disorder				
Osteoporosis					Alchoholism				
Lupus					Drug Addiction				
Sjogren's									

Fibromyalgia						Hepatitis (A/B/C)				
						Sickle Cell Anemia/Trait				
Asthma									*OVER*	
COPD/Emphysema										

PLEASE LIST ALL PRESCRIPTION OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING TO INCLUDE: EYE DROPS, ORAL MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS

Name_____

No Prescription drugs needed r

No supplements being taken r

Multivitamin? No r Yes r Brand:_____

Omega 3 supplement? No r Yes r Brand:_____

Medication/Supplement	Dose	Frequency	Route	Diagnosis/Disease	Prescribing Doctor

Previous Surgeries	RT/LT/BOTH	Year	Surgeon	City

Recent Hospitalization	Year	Doctor	Diagnosis