Patient Form

Ramsey Eye Care Center

General Information

First, MI, Last Name:

DOB: SSN: Male / Female

Home Address:

Street/ PO Box *City* *State* *Zip*

Billing Address:

Home Phone: Work Phone: Cell Phone:

Email:

Preferred Contact Method *(please indicate)* *cell phone / email / text / other*

Marital Status *single / married / other*

Language, Race, Ethnicity

Emergency Contact Person and Phone

Employer/Occupation *full-time / part-time*

INSURANCE INFORMATION

Vision Plan

Member Name Member DOB

Policy Number or ID #/SSN

Relationship to Member *spouse / child / other (please explain)*

Primary Medical Insurance Carrier

Member Name Member DOB

Policy Number or ID #/SSN

Relationship to Member *spouse / child / other (please explain)*

Secondary Medical Insurance Carrier

Member Name Member DOB

Policy Number or ID #/SSN

Relationship to Member *spouse / child / other (please explain)*

Guarantor (for a minor): Relation:

DOB SSN

Ph. Email

Address:

Street/ PO Box *City* *State* *Zip*

PLEASE BRING INSURANCE CARDS AND A CURRENT MEDICATION LIST TO YOUR APPOINTMENT

Health History

Date of Last Eye Exam

Do You Currently Wear Glasses?

Do You Currently Wear Contactss?

Reason for Today's Visit?

Do you smoke? [ ] Have you ever smoked? [ ]

Have you or a family member experienced or been treated, for any of the following? Circle all that apply.

Cataracts	Self	Family
Crossed Eye	Self	Family
Glaucoma	Self	Family
Lasik or PRK	Self	Family
Lazy Eye	Self	Family
Macular Degeneration	Self	Family
Retinal Detachment	Self	Family
Keratoconus	Self	Family

Are your currently experiencing, or have experienced, any of the following? Check all that apply.

[ ] Blurry Vision Near [ ] Blurry Vision Distance

[ ] Burning [ ] Redness

[ ] Discharge

[ ] Double Vision

[ ] Dryness [ ] Sandy /Gritty Feeling

[ ] Excess Tearing/Watering

[ ] Eye Infection

[ ] Eye Pain or Soreness

[ ] Floaters or Spots

[ ] Halos

[ ] Headaches

[ ] Itching

[ ] Light Flashes

[ ] Seasonal Allergies

[ ] Allergies to Medication _____

Have you or an immediate family member experienced or been treated for any of the following?

Circle (Self) (Family) for all that apply.

Aids/HIV	Self	Family
Allergies	Self	Family
Arthritis	Self	Family
Asthma	Self	Family
Blood/Lymph Disorder	Self	Family
Cancer	Self	Family
Diabetes	Self	Family
Ears, Nose, Throat	Self	Family
Gastrointestinal Conditions	Self	Family
Heart Disease	Self	Family
High Blood Pressure	Self	Family
High Cholesterol	Self	Family
Kidney Disease	Self	Family
Lupus	Self	Family
Neurological Conditions	Self	Family
Psychiatric Disorder	Self	Family
Seizures	Self	Family
Skin Conditions	Self	Family
Stroke	Self	Family
Thyroid Dysfunction	Self	Family

Current Medications, Dosage and Times/Day:

Height Weight

Right Handed ____ Left Handed ____

Are you Pregnant or nursing? Yes____ NO____

Patient Authorization to Disclose Protected Health Information

I,_____, understand Ramsey Eye Care Center is authorized by me to disclose my personal "Protected Health Information" in the manner(s) that I have checked below and to the individuals that I have listed below.

I wish to be contacted in the following manner (check all that apply):

□ Home Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Work Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Cell Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Written Communication:
- □ O.K. to email _____
- □ O.K. to mail my home
- □ O.K. to mail to my work/office
- □ O.K. to fax to this #_____

Ramsey Eye Care Center is authorized by this signed form to disclose or discuss my "Protected Health Information" with the following named individuals:

Name:

_____□ Medical □ Appointment □ Product Pick-Up

_____□ Medical □ Appointment □ Product Pick-Up

_____□ Medical □ Appointment □ Product Pick-Up

_____□ Medical □ Appointment □ Product Pick-Up

I understand that I have the right to revoke any individual listed on this authorization. That request must be made in writing before that request can be processed. This process can take up to three (3) days once received by our office. I fully understand and accept the terms of this authorization.

Patient Signature:_____ Date:_____

Office Use: _____ Date:_____