RIDGEFIELD OPHTHALMOLOGY PATIENT INFORMATION

BIOGRAPHICAL

LAST FIRST MIDDLE

PATIENT NAME: _____

STREET/BOX # CITY STATE ZIP

ADDRESS: _____

DATE OF BIRTH (MM/DD/YEAR): _____ SOCIAL SECURITY NUMBER: _____

PHONE(S): HOME _____CELL _____WORK _____

EMAIL (Please write legibly): _____

WOULD YOU LIKE TO SUBSCRIBE TO EMAIL APPOINTMENT REMINDERS? (Check one) YES _____ NO _____

GENDER: FEMALE / MALE / OTHER: _____

MARITAL STATUS (Circle one): SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO RESPONSBILE PARTY (Circle one): SELF SPOUSE CHILD OTHER

HOW DID YOU HEAR ABOUT US? (Circle one): FRIEND PHYSICIAN WEBSITE NEWSPAPER

YOUR PHYSICIAN

PRIMARY CARE PHYSICIAN (PCP): _____ REFERRED BY (if applicable): _____

PCP ADDRESS: _____ PCP PHONE: _____

YOUR OCCUPATION

OCCUPATION: _____ COMPANY: _____ PHONE: _____

HEALTH INSURANCE

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE:

PRIMARY INSURANCE COMPANY NAME:

ADDRESS:_____ PHONE: _____

MEMBER (ID / POLICY / CONTRACT) NUMBER: _____ COPAYMENT AMOUNT ($): _____

GROUP NAME: _____ GROUP NUMBER: _____

SECONDARY INSURANCE COMPANY (fill this section *only* if you have one):

ADDRESS:_____ PHONE: _____

MEMBER (ID / POLICY / CONTRACT) NUMBER: _____ COPAYMENT AMOUNT ($): _____

GROUP NAME: _____ GROUP NUMBER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION (Fill in only if the primary insured person is not you):

RESPONSIBLE PARTY NAME (Last, First, Middle): _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____ GENDER: FEMALE / MALE / OTHER: _____

PHONE(S): HOME _____ CELL _____ WORK _____ EMAIL: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____ PHONE: _____

MEDICAL HISTORY

DO YOU HAVE ANY CHRONIC ILLNESSES SUCH AS: DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE, ETC.?

_____

_____

DO YOU HAVE, OR HAVE YOU EVER HAD? (Circle YES or NO, and if YES, describe below)

YES	NO	HIGH BLOOD PRESSURE?	YES	NO	SKIN DISEASE?
YES	NO	HIGH CHOLESTEROL?	YES	NO	HEADACHES?
YES	NO	HEART PROBLEMS?	YES	NO	STROKE?
YES	NO	SINUS INFECTIONS?	YES	NO	DEPRESSION OR PSYCHIATRIC DISORDERS?
YES	NO	ASTHMA/ BREATHING DISEASE	YES	NO	DIABETES OR HORMONAL DISORDERS?
YES	NO	TUBERCULOSIS?	YES	NO	ANEMIA?
YES	NO	LIVER DISEASE?	YES	NO	OTHER BLOOD DISORDERS?
YES	NO	DIGESTIVE DISEASE / DISORDERS?	YES	NO	HISTORY OF TRAUMA OR SERIOUS INJURY?
YES	NO	ULCERS?	YES	NO	KELOID FORMATION?
YES	NO	GENITOURINARY DISEASE? ARE YOU ON FLOMAX?	YES	NO	DO YOU TAKE BLOOD THINNERS: (ASPIRIN, COUMADIN, PLAVIX, LOVENOX etc.)
YES	NO	ARE YOU PREGNANT OR NURSING?	YES	NO	HAVE YOU TAKEN STEROIDS?
YES	NO	VENEREAL DISEASE?	YES	NO	HAYFEVER OR SEASONAL ALLERGIES?
YES	NO	KIDNEY DISEASE?	YES	NO	TUMOR OR CANCER?
YES	NO	ARTHRITIS?	YES	NO	HIV, TB OR HEPATITIS POSITIVE?
YES	NO	SLEEP APNEA?	YES	NO	RAYNAUD'S?

_____

_____

HAVE YOU EVER HAD COSMETIC/PLASTIC SURGERY? IF SO, STATE TYPE: _____

PLEASE LIST CHRONOLOGICALLY, WITH DATES, ALL HOSPITALIZATIONS OR SURGERIES YOU HAVE HAD:

_____

_____

PLEASE NAME YOUR DOCTORS AND THE REASON YOU NEED TO SEE THEM:

_____

_____

_____

PLEASE PRINT ALL OF YOUR PRESCRIPTION AND NONPRESCRIPTION MEDICATION(S):

NAME DOSE HOW OFTEN DURATION WHY DO YOU TAKE IT?

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

HAVE YOU EVER SMOKED? IF SO, HOW MUCH AND FOR HOW LONG? _____

HOW MUCH ALCOHOL DO YOU DRINK PER DAY? _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMI LY EVER HAD (Circle YES or NO, and if YES, describe below)

YES	NO	CATARACTS?	YES	NO	ANY EYE OPERATIONS?
YES	NO	GLAUCOMA?	YES	NO	MACULAR DEGENERATION?
YES	NO	RETINAL DETACHMENT?	YES	NO	OTHER FAMILY EYE DISEASE?
YES	NO	BLINDNESS?	YES	NO	DIABETES?
YES	NO	CANCER?	YES	NO	HEREDITARY DISEASE?
YES	NO	DID YOUR PARENTS SEE WELL?	YES	NO	MALIGNANT HYPERTHERMIA?

PERSONAL EYE HISTORY

PLEASE STATE THE MAIN REASON YOU ARE HERE TODAY TO HAVE YOUR EYES EXAMINED:

IF YOU HAVE A PROBLEM, WHERE DID IT START? RIGHT EYE: _____ LEFT EYE: _____

PREVIOUS EYE DOCTOR: _____

PRESENT EYE MEDICATIONS:

NAME DOSE HOW OFTEN DO YOU TAKE FOR HOW LONG HAVE YOU TAKEN

WHICH ONE OF YOUR EYES IS DOMINANT (Circle one if known): RIGHT / LEFT

DO YOU WEAR CONTACT LENSES? _____ FOR HOW LONG? _____ LAST REPLACED? _____

CHECK ALL THAT APPLY: SOFT ____ HARD ____ DAILY WEAR ____ DISPOSIBLE ____ MONOVISION ___ BIFOCAL___

HAVE YOU HAD A RECENT PROBLEM WITH YOUR CONTACT LENSES?

DO YOU HAVE OR HAVE YOU EVER HAD? (Circle YES or NO, and if YES, describe below)

YES	NO	BLURRED VISION?	YES	NO	GLAUCOMA?
YES	NO	EYE INFECTIONS OR CORNEAL ULCERS?	YES	NO	EYE SURGERIES?
YES	NO	EYE INJURIES	YES	NO	DIFFICULTY SEEING AT NIGHT, GLARE OR HALOS?
YES	NO	FLASHES OR FLOATERS?	YES	NO	AMBLYOPIA (LAZY EYE)?
YES	NO	CROSSED EYES OR DOUBLE VISION?	YES	NO	HEADACHES?
YES	NO	DRY EYES?	YES	NO	EYELID SURGERY?

RIDGEFIELD OPHTHALMOLOGY

PLEASE READ THE FOLLOWING CAREFULLY AND ASK ANY QUESTIONS YOU WISH BEFORE SIGNING

PATIENT NAME: _____ DOB (MM/DD/YEAR): _____

As a courtesy, we will bill your insurance company for payments for your exam and any treatment; however we will need your cooperation in collecting the payments from them. Please respond to requests for additional or corrected information from our staff in a timely manner and pay any deductible amount, co-insurance or any other balance not paid by your insurance company.

*HSA POLICY: If you have a health savings account insurance plan and your deductible has not been met, we request payment at time of service. Your exam can range anywhere from $150 - $300 and testing may be additional.

I hereby authorize RIDGEFIELD OPHTHALMOLOGY to submit a claim to my insurance carrier or the intermediaries for all services rendered by RIDGEFIELD OPHTHALMOLOGY and direct my insurance carrier or its intermediaries to issue payments directly to RIDGEFIELD OPHTHALMOLOGY. I hereby authorize RIDGEFIELD OPHTHALMOLOGY to release all information necessary regarding services rendered to my insurance company and referring physicians.

I have been informed that not all services at RIDGEFIELD OPHTHALMOLOGY (such as contact lens checks, Optomaps, etc.) are covered by insurance companies. I **agree to pay for all "non-covered services" if applicable.**

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER THEY ARE PAID OR NOT PAID (COMPLETELY OR PARTIALLY) BY MY INSURANCE COMPANY. **I understand that in order to cover my services, a referral from my primary care physician may be necessary. I also understand that if RIDGEFIELD OPHTHALMOLOGY does not receive a written authorization or referral from my primary care physician,** I will be held financially responsible and pay for any and all charges incurred.

Patient Signature**:** _____ Date: _____

HIPPA PRIVACY RESTRICTIONS

I acknowledge that I have had an opportunity to review a copy of the RIDGEFIELD OPHTHALMOLOGY Notice of Privacy Restrictions which describes how my health insurance information can be protected and the rights that I have regarding my health information. PLEASE CHECK ONE OF THE BOXES BELOW:

I have no particular privacy request: ☐

I wish to make the following restrictions: ☐

If we need to leave a message which phone number(s) is/are best to call? May we leave message(s) at that phone number(s)? With whom can we leave messages?

_____

_____

_____

Patient Signature**:** _____ Date: _____