RICHENS EYE CENTER
Vision for Life

PATIENT INFORMATION

Date:_____

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

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_____

Date: _____Name: _____

EYE HEALTH

Date of last eye exam: _____ By Dr.: _____
Do you wear glasses? ❒Yes ❒No Do you wear Contacts: ❒Yes ❒No Type:_____
Do you drive? ❒Yes ❒No Do you drive at night? ❒Yes ❒No Are you interested in Refractive surgery? ❒Yes ❒No
Why are we seeing you today? How can we help you?:_____

MEDICATIONS

List any medications you are currently taking (including Eye drops, Herbal supplements and Vitamins) ❒ NONE

_____

_____

List your allergies to medications or other substances: ❒ NONE

_____

Circle if you have taken any of the following, Flomax, Uroxatrol, Hytrin, Cardura, Proscar or Saw Palmetto?
Please list which Pharmacy you would like prescriptions called into: _____

HEALTH HISTORY

PRIMARY CARE PHYSICIAN: _____
List all previous surgeries (including eye surgery): ❒ **NONE**

_____

Do you smoke? ❒Yes _____ pk/day how many years_____
❒No Did you ever smoke? ❒ Yes ❒ No _____ pk/day how many years_____
If you quit, when did you quit? _____

Please check any of the following that apply to **YOURSELF AND FAMILY**

	Self	Mother	Father	Siblings	Other
Allergy	❒	❒	❒	❒	❒
Asthma	❒	❒	❒	❒	❒
Blindness/Low vision	❒	❒	❒	❒	❒
Arthritis (RA/ OSTO/ Other Circle)	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒
Degenerative disorder of macula	❒	❒	❒	❒	❒
Depression	❒	❒	❒	❒	❒
Diabetes Mellitus	❒	❒	❒	❒	❒
Eye Disorder	❒	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	❒
Hearing loss	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒	❒
Ischemic Heart Disease	❒	❒	❒	❒	❒
Lupus	❒	❒	❒	❒	❒
Malignant Melanoma	❒	❒	❒	❒	❒
Malignant tumor of brain	❒	❒	❒	❒	❒
Malignant tumor of eye proper	❒	❒	❒	❒	❒
Migraines	❒	❒	❒	❒	❒
Multiple Sclerosis	❒	❒	❒	❒	❒
Neurological Disorder	❒	❒	❒	❒	❒
Prostate Cancer	❒	❒	❒	❒	❒
Seizure Disorder	❒	❒	❒	❒	❒
Sick Cell Trait	❒	❒	❒	❒	❒
Sickle Cell Anemia	❒	❒	❒	❒	❒
Thyroid Disorder	❒	❒	❒	❒	❒
Uveitis	❒	❒	❒	❒	❒

Please check any of the following that apply to **ONLY YOURSELF**

	Yes	No
Amblyopic (lazy eye)	❒	❒
Cataract	❒	❒
Diabetic Retinopathy	❒	❒
Chemical Dependency	❒	❒
Double Vision	❒	❒
Dry Eyes	❒	❒
Floaters (new/old)	❒	❒
Macular Degeneration	❒	❒
Retinal Detachment	❒	❒
Strabismus	❒	❒
Alcohol Use	❒	❒
Are you pregnant?	❒	❒
Coronary Artery Dz	❒	❒
Emphysema	❒	❒
Heart Attack	❒	❒
Hepatitis (A/B/C)	❒	❒
Kidney Disease	❒	❒
Osteoporosis	❒	❒
Pacemaker	❒	❒
Pneumonia Vaccination	❒	❒
Prostate Problems	❒	❒
Shingles	❒	❒
Stent Valve Repair	❒	❒
Stroke	❒	❒
Sjogrens	❒	❒

Dry Eye **Questionnaire**

Patient Name or ID: _____ **Date:**_____

Technician: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Y☐ N When? _____

Do you have the following symptoms?

☐ Blurry vision
☐ Redness
☐ Burning
☐ Itching
☐ Light Sensitivity
☐ Excess tearing/watering eyes
☐ Tired eyes, eye fatigue
☐ Stringy mucus in or around the eyes
☐ Foreign body sensation
☐ Contact lens discomfort
☐ Scratchy feeling of sand or grit in the eye

Have you had any of the following surgeries?

Cataract: ☐Y ☐ N Glaucoma: ☐ Y ☐ N Refractive Surgery: ☐ Y☐ N

Do you use?

☐ Contact lenses
☐ OTC eye drops such as artificial tears
☐ Rx eye drops for Dry Eye Syndrome (e.g., Restasis)
☐ Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)
☐ Rx eye drops for Allergy (e.g., anti-inflammatory, antihistamine)
☐ Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

☐ Windy Conditions
☐ Places with low humidity (e.g., airplanes/hospital)
☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

☐ Antihistamines/decongestants
☐ Oral corticosteroids
☐ Acutane or other oral treatment for acne
☐ Antidepressant or anti-anxiety
☐ Hormone replacement therapy or estrogen
☐ Antihypertensives (e.g., diurectic, beta-blocker)

Have you ever had punctual occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical data, raises the suspicion for Dry Eye Disease, then obtaining a Tear Osmolarity Test may be indicated.
I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has Dry Eye Disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: _____ Date: _____