Robert A. Ring, O.D.

PATIENT HISTORY AND INFORMATION

☐ Dr. ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone | Who were you referred by?

Current Occupation | Employer | Yrs | Drivers License

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient/Dr. Who? _____ ☐ Insurance Listing ☐ Drive by ☐ Other

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

***FINANCIAL POLICY: FEES FOR SERVICES MUST BE PAID FOR IN FULL WHEN THE SERVICES ARE RENDERED. WHEN GLASSES OR CONTACT LENSES ARE ORDERED, THE FULL PAYMENT IN ADVANCE IS PREFERRED. IN SOME INSTANCES, A DEPOSIT OF ½ THE FEE FOR MATERIALS CAN BE MADE AT THE TIME OF ORDERING WITH THE COMPLETE BALANCE DUE UPON DELIVERY. MATERIALS REMAIN THE PROPERTY OF THIS OFFICE UNTIL PAID IN FULL. DUE TO LAB POLICIES, ONCE ORDERS HAVE BEEN PROCESSED THEY CANNOT BE CANCELLED. CREDITS ARE IN HOUSE CREDITS ONLY.

AS A COURTESY TO YOU WE ARE HAPPY TO BILL YOUR INSURANCE FOR SERVICES AND MATERIALS RENDERED. **PLEASE BE ADVISED THAT PROOF OF INSURANCE BENEFITS DO NOT GUARANTEE PAYMENT IN WHOLE OR IN PART BY YOUR INSURANCE CARRIER NOR DOES IT IMPLY THAT THE DOCTORS SERVICES OR MATERIALS OBTAINED AT OUR PRACTICE IS A COVERED PAID BENEFIT.**

WE APPRECIATE YOUR PATIENCE WHILE WE COMPLETE THE BILLING PROCESS. IN MOST CASES, WE WILL HAVE VERIFICATION OF BENEFITS ONCE A CLAIM IS FILED OR WITHIN 90 DAYS. HOWEVER, IN SOME CASES IT MAY TAKE LONGER.

IF YOUR INSURANCE DENIES YOUR CLAIM FOR COVERAGE ON SERVICES RENDERED, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

WE APPRECIATE YOUR PATRONAGE AND WILL MAKE EVERY EFFORT TO MAKE THE EXPERIENCE IN OUR OFFICE A PLEASANT AND SATISFYING ONE.

***A ONE AND ONE-HALF (1½) PERCENT MONTHLY **FINANCE CHARGE** IS ADDED TO ALL LATE DUE AMOUNTS. THIS REPRESENTS AN **ANNUAL PERCENTAGE RATE** OF EIGHTEEN (18) PERCENT.

MAY WE CONTACT YOU BY E-MAIL FOR RECALL AND WITH OFFICE INFORMATION? YES NO

*****I HEREBY AUTHORIZE DR. RING TO RELEASE ALL INFORMATION NECESSARY TO MEDICAL AND VISION COVERAGE CARRIERS.

Signature | Date

EYE CARE HISTORY

SPECTACLE LENS HISTORY

Do you use a computer? ◯ Yes ◯ No How many hours/day? _____ Distance from Computer? _____

Do you have glare problems? ◯ Yes ◯ No Do you have problems with night vision? ◯ Yes ◯ No

Do you have visual difficulty when driving? ◯ Yes ◯ No Do you currently wear glasses? ◯ Yes ◯ No

Glasses Owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive ☐ Sunglasses

Have you had trouble in the past with glasses? ◯ Yes ◯ No _____

Family members who wear glasses _____

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ◯ Yes ◯ No Reason for stopping? _____

Do you currently wear contact lenses? ◯ Yes ◯ No How often? _____

Type and brand of contact lenses _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ◯ Yes ◯ No

Do you engage in regular exercise? ◯ Yes ◯ No

Do you drink alcohol? If yes, how much/often: ◯ No ◯ Occasional ◯ 1 Per Day ◯ 2-3/day ◯ 4+/day

Do you smoke? If yes, how much/often: ◯ No ◯ Occasional ◯ 1/2 pack/day ◯ 1 pack/day ◯ 1+ pack

Method of Tobacco Intake: ◯ Smoking ◯ Chewing

Do you use Illegal Drugs: ◯ Yes ◯ No

Hobbies/ Interests: _____

MEDICAL HISTORY QUESTIONNAIRE

PRIMARY CARE PHYSICIAN

_____

Primary Care Physician and Clinic Name Address City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam? _____ When was your last exam? _____ When was your last health exam? _____

Past Illnesses or Injuries: _____ Current Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____ Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____ Specific Allergies: _____

EYE HISTORY

Glaucoma	◯ Yes ◯ No	Dryness	◯ Yes ◯ No	Strabismus (Crossed Eyes)	◯ Yes ◯ No
Cataract	◯ Yes ◯ No	Excess Tearing/Watering	◯ Yes ◯ No	Blurred Vision Distance	◯ Yes ◯ No
Macular Degeneration	◯ Yes ◯ No	Eye Pain or Soreness	◯ Yes ◯ No	Blurred Vision Near	◯ Yes ◯ No
Retinal Detachment	◯ Yes ◯ No	Infection of Eye or Lid	◯ Yes ◯ No	Distorted Vision (halos)	◯ Yes ◯ No
Headaches	◯ Yes ◯ No	Itching	◯ Yes ◯ No	Double Vision	◯ Yes ◯ No
Glare/Light Sensitivity	◯ Yes ◯ No	Mucous Discharge	◯ Yes ◯ No	Floaters or Spots	◯ Yes ◯ No
Tired Eyes	◯ Yes ◯ No	Drooping Eyelid	◯ Yes ◯ No	Fluctuating Vision	◯ Yes ◯ No
Amblyopia (Lazy Eye)	◯ Yes ◯ No	Redness	◯ Yes ◯ No	Loss of Vision	◯ Yes ◯ No
Burning	◯ Yes ◯ No	Sandy or Gritty Feeling	◯ Yes ◯ No	Loss of Side Vision	◯ Yes ◯ No

GENERAL HEALTH CONDITION

Fever	◯ Yes ◯ No	Respiratory (Asthma)	◯ Yes ◯ No	Neurological (MS)	◯ Yes ◯ No
Weight Loss	◯ Yes ◯ No	Gastrointestinal	◯ Yes ◯ No	Thyroid, Diabetes	◯ Yes ◯ No
Other Symptoms	◯ Yes ◯ No	Kidney	◯ Yes ◯ No	Blood/Lymph	◯ Yes ◯ No
Ears, Nose, Throat	◯ Yes ◯ No	Muscles, Bones, Joints	◯ Yes ◯ No	HIV	◯ Yes ◯ No
Cardiovascular (High BP)	◯ Yes ◯ No	Skin	◯ Yes ◯ No		

Are you? ☐ Pregnant ☐ Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	◯ Yes ◯ No	Retinal Detachment	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Blindness	◯ Yes ◯ No	Strabismus (Eye Turn)	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No
Cataract(s)	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Lupus	◯ Yes ◯ No
Color Blindness	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Macular Degeneration	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Others	◯ Yes ◯ No