Welcome to Our Office

Name_____ Nick Name_____

Street_____

City_____State_____Zip_____

Home Phone_____

Cell Phone_____

Winter address _____

City _____State_____Zip_____

Social Security Number_____

Employer_____

Occupation_____

Hobbies_____

Email Address_____

Today's date_____Date of last exam_____

Were you dilated? (Drops) Y/N Gender M____F____

Date of Birth_____ Age_____

Marital status_____

Spouse (or Parent) name_____

Primary Policy Holder Name_____DOB_____

How will you settle your account today?

☐ Check ☐ Cash ☐ Credit Card

Please tell us your chief complaint

_____

_____

How is your general health? _____

Do you take medication for any of these symptoms? (*Please circle yes or no*)

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine(glands)	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood/lymph	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic/Immunologic	Y / N
Respiratory	Y / N	Integumentary	Y / N	Headaches	Y / N
High Blood Pressure	Y / N	Eyes	Y / N	Mental	Y / N

Diabetes Yes/No_____ Type_____ Date of Diagonosis_____
Allergies to medication Yes/No Which? _____ Reaction? _____
Other Health Problems _____
Have you had any operations? Yes/No Kind?_____ When?_____
Name of Primary doctor and/or primary care physician _____
Date of last visit_____ Date your blood pressure was last checked _____

Family History

High Blood Pressure	Yes/No	Relation_____	Mascular degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What Kinds?_____ Date_____
Have you had any eye operations? Yes/No Type_____Date_____
Have you had any eye injury? Yes/No Kind_____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Mascular degeneration?	Yes/No	Retinal detachment	Yes/No	Blurred Vision	Yes/No
Do you wear Glasses?	Yes/No	Contact Lenses?	Yes/No	Type_____	

Additional Information_____

Current Medications_____

_____

_____

Signature on file

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Ravine Eye Center/ Eye Group for any services furnished to me By that physician. I authorize any holder of medical information about me to be released to the health Care Financing Administration and its agents any information needed To determine these benefits or benefits payable for related services. I also understand that I am financially responsible for services rendered if my insurance company not remit.

Signature _____ Date_____