Ridgedale Family Eye Care Registration and History Form

PATIENT INFORMATION

Patient Name: _____ _____ _____
Last Name First Name Middle Initial

Address _____ City _____

State _____ Zip Code _____

E-mail _____

Home Phone _____ Cell Phone _____

Work Phone _____ Occupation _____

Date of Birth _____ Sex ☐Male ☐Female

SS# _____

☐Married ☐Divorced ☐Single

☐Seperated ☐Widowed ☐Minor

How did you hear about our office ?_____

EMERGENCY CONTACT

Name_____ Relationship _____

Home Phone_____ Cell_____ Work _____

MEDICAL INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient? _____ SS# _____

Date of birth _____

Insurance Co. _____

Policy # _____ Group # _____

Is patient covered under additional insurance? ☐Yes ☐No

Insurance Co. _____

Subscribers name _____ SS# _____

Date of birth _____

Policy# _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s) have insurance coverage with (insurance co.)_____ and assign directly to Dr Jerrold Fruchtman all benefits, If any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions
The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. This consent will end when my current treatment plan is completed or one year from the date signed below

Signature of Patient, Parent, Guardian or Personal Representative_____ Date_____

Please Print Name of Patient, Guardian, or Personal Representative _____

EYE HEALTH HISTORY

Date of last eye exam_____

Do you wear eyeglasses: ☐Yes☐No / If Yes ☐Full Time ☐Ocassionally ☐Reading ☐Driving/TV

Do you wear contact lenses ☐Yes ☐No

How often do you discard your contacts? ☐Daily ☐Weekly ☐Biweekly ☐Monthly ☐Quarterly

Do you take your contacts out at night? ☐Yes ☐No

What disinfection system do you use? _____

Please describe any problems your are having with your contacts _____

_____

Please mark Yes or No to indicate if you have experienced any of the following

Bloodshot Eyes	☐Yes ☐No	Light Flashes	☐Yes ☐No
Blurred Vision- Distance	☐Yes ☐No	Itchy Eyes	☐Yes ☐No
Blurred Vision- Near	☐Yes ☐No	Watery Eyes	☐Yes ☐No
Discharge from Eyes	☐Yes ☐No	Light Sensitive	☐Yes ☐No
Dry/Sandy Eyes	☐Yes ☐No	Headaches	☐Yes ☐No
Eye Injury	☐Yes ☐No	Seeing Halos	☐Yes ☐No
Eyestrain	☐Yes ☐No	Glaucoma	☐Yes ☐No
Floaters/Spots	☐Yes ☐No	Cataracts	☐Yes ☐No
Poor Night Vision	☐Yes ☐No	Double Vision	☐Yes ☐No

Other_____

HEALTH HISTORY

Please mark Yes or No if you have had any of the following. Also mark for family history as well.

	Yourself	Family		Yourself	Family
Arthritis	☐Yes ☐No	☐Yes ☐No	Hepatitis	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No	Hypertension	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No	Kidney Disease	☐Yes ☐No	☐Yes ☐No
Cataracts	☐Yes ☐No	☐Yes ☐No	Lazy Eye	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No	Retinal Disease	☐Yes ☐No	☐Yes ☐No
Eye Surgery	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	☐Yes ☐No
Glaucoma	☐Yes ☐No	☐Yes ☐No	Thyroid Condition	☐Yes ☐No	☐Yes ☐No
Heart Condition	☐Yes ☐No	☐Yes ☐No	Tuberculosis	☐Yes ☐No	☐Yes ☐No
Pregnant	☐Yes ☐No	☐Yes ☐No	Alcohol Use	☐Yes ☐No	
Tobacco Use	☐Yes ☐No		Tobacco Use	☐Yes ☐ No	

Please list any medications you are currently taking _____

_____

Please list any allergies to medication _____