

# 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 1/2 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 (1 1/2) 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 <input type="radio"/> Yes <input type="radio"/> No	Dryness <input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes) <input type="radio"/> Yes <input type="radio"/> No
Cataract <input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering <input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance <input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness <input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near <input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment <input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid <input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos) <input type="radio"/> Yes <input type="radio"/> No
Headaches <input type="radio"/> Yes <input type="radio"/> No	Itching <input type="radio"/> Yes <input type="radio"/> No	Double Vision <input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity <input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge <input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots <input type="radio"/> Yes <input type="radio"/> No
Tired Eyes <input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid <input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision <input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye) <input type="radio"/> Yes <input type="radio"/> No	Redness <input type="radio"/> Yes <input type="radio"/> No	Loss of Vision <input type="radio"/> Yes <input type="radio"/> No
Burning <input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling <input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision <input type="radio"/> Yes <input type="radio"/> No

### GENERAL HEALTH CONDITION

Fever <input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma) <input type="radio"/> Yes <input type="radio"/> No	Neurological (MS) <input type="radio"/> Yes <input type="radio"/> No
Weight Loss <input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal <input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes <input type="radio"/> Yes <input type="radio"/> No
Other Symptoms <input type="radio"/> Yes <input type="radio"/> No	Kidney <input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph <input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat <input type="radio"/> Yes <input type="radio"/> No	Muscles, Bones, Joints <input type="radio"/> Yes <input type="radio"/> No	HIV <input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (High BP) <input type="radio"/> Yes <input type="radio"/> No	Skin <input type="radio"/> Yes <input type="radio"/> No	Are you? <input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing

### FAMILY HISTORY

Amblyopia (Lazy Eye) <input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Blindness <input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn) <input type="radio"/> Yes <input type="radio"/> No	Kidney Disease <input type="radio"/> Yes <input type="radio"/> No
Cataract(s) <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No	Lupus <input type="radio"/> Yes <input type="radio"/> No
Color Blindness <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No	Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Others <input type="radio"/> Yes <input type="radio"/> No