

Welcome To Our Office

Welcome to Ross Eyecare Group, P.C.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

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 Cell Phone

Email Address Spouse or Parent(s) Name Person Responsible for Account (Must sign at bottom)

Height	ft	in	cm/m	<input checked="" type="radio"/> ft in <input type="radio"/> cm <input type="radio"/> m
Weight	<input checked="" type="radio"/> lbs <input type="radio"/> kg			

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American
<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	
<input type="checkbox"/> Other Race _____	

Ethnicity Hispanic Or Latino Not Hispanic Or Latino Unknown

Preferred Language English Spanish French Italian Russian Portuguese

How were you referred to our office?

<input type="checkbox"/> Phone Book	<input type="checkbox"/> School	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Patient (Please Name) _____
<input type="checkbox"/> Insurance Listing	<input type="checkbox"/> Drive by	<input type="checkbox"/> Other _____	<input type="checkbox"/> Doctor (Please Name) _____

Primary Insurance Information

Name and Address of Primary Insurance Company or Routine Vision Provider 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		Patient Status
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
		<input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/> Employed

Secondary Insurance Information

Name and Address of Secondary 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		
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Ross Eyecare Group, P.C.. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date

Name

Ross Eyecare Group, P.C.

PATIENT HISTORY AND INFORMATION

Dr.

Primary Care Provider

Name Of Provider's Office

Phone Number

VISUAL HISTORY

Current Occupation : _____ Years _____ Employer _____

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

Do you drive? Yes No Mileage to work each way _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

CONTACT LENS HISTORY

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

Do you currently wear contact lenses ? Yes No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left Right Left Right Left

Lens Comfort : _____ Distance Vision : _____ Near Vision : _____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SPECTACLE LENS HISTORY

Do you currently wear glasses ? Yes No Since _____

Use of glasses Full Time Part Time Distance Close

Glasses Owned

Single Vision Bifocals Trifocals Backup Safety Sports Progressive

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

Do you wear sunglasses ? Yes No Are your sunglasses your current prescription ? Yes No

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

Hobbies/ Interests : _____

SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

Name _____

Ross Eyecare Group, P.C.
MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

- | | | | | | |
|-------------------------|---------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| Headaches | <input type="radio"/> Yes | <input type="radio"/> No | Blurred Vision Distance | <input type="radio"/> Yes | <input type="radio"/> No |
| Glare/Light Sensitivity | <input type="radio"/> Yes | <input type="radio"/> No | Blurred Vision Near | <input type="radio"/> Yes | <input type="radio"/> No |
| Tired Eyes | <input type="radio"/> Yes | <input type="radio"/> No | Distorted Vision (halos) | <input type="radio"/> Yes | <input type="radio"/> No |
| Lazy Eye | <input type="radio"/> Yes | <input type="radio"/> No | Double Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Burning | <input type="radio"/> Yes | <input type="radio"/> No | Floaters or Spots | <input type="radio"/> Yes | <input type="radio"/> No |
| Dryness | <input type="radio"/> Yes | <input type="radio"/> No | Fluctuating Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Excess Tearing/Watering | <input type="radio"/> Yes | <input type="radio"/> No | Loss of Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Eye Pain or Soreness | <input type="radio"/> Yes | <input type="radio"/> No | Loss of Side Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Foreign Body Sensation | <input type="radio"/> Yes | <input type="radio"/> No | Drooping Eyelid | <input type="radio"/> Yes | <input type="radio"/> No |
| Infection of Eye or Lid | <input type="radio"/> Yes | <input type="radio"/> No | Redness | <input type="radio"/> Yes | <input type="radio"/> No |
| Itching | <input type="radio"/> Yes | <input type="radio"/> No | Sandy or Gritty Feeling | <input type="radio"/> Yes | <input type="radio"/> No |
| Mucous Discharge | <input type="radio"/> Yes | <input type="radio"/> No | Crossed Eyes | <input type="radio"/> Yes | <input type="radio"/> No |

GENERAL HEALTH CONDITION

- | | | | | | |
|------------------------|---------------------------|--------------------------|-------------------------------|---------------------------|--------------------------|
| Fever | <input type="radio"/> Yes | <input type="radio"/> No | Kidney | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight Loss | <input type="radio"/> Yes | <input type="radio"/> No | Muscles,Bones, Joints | <input type="radio"/> Yes | <input type="radio"/> No |
| Other Consti. Symptoms | <input type="radio"/> Yes | <input type="radio"/> No | Skin | <input type="radio"/> Yes | <input type="radio"/> No |
| Ears,Nose,Throat | <input type="radio"/> Yes | <input type="radio"/> No | Neurological (MS) | <input type="radio"/> Yes | <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | Anxiety, Depression, Insomnia | <input type="radio"/> Yes | <input type="radio"/> No |
| Respiratory (Asthma) | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes,thyroid | <input type="radio"/> Yes | <input type="radio"/> No |
| Gastrointestinal | <input type="radio"/> Yes | <input type="radio"/> No | Blood/Lymph (cholesterol) | <input type="radio"/> Yes | <input type="radio"/> No |
| Psychiatric | <input type="radio"/> Yes | <input type="radio"/> No | Allergic/Immunologic | <input type="radio"/> Yes | <input type="radio"/> No |

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

if yes, who?

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

INSURANCE RESPONSIBILITY

I, the undersigned, understand that I am ultimately responsible for payment in full for all charges incurred by me at Ross Eyecare Group, P.C. If my insurance company does not pay for services rendered or materials furnished by Ross Eyecare Group, P.C., or if for any reason my deductible has not been met, it is my responsibility to pay the usual and customary fees for said services and materials. I also realize that I am responsible for any co-payment and deductible required under my insurance. If this matter becomes a collection matter, I will assume all attorneys' fees, collection costs, and court costs incurred by Ross Eyecare Group, P.C. in its attempt to collect any and all outstanding debt on my account.

I authorize Ross Eyecare Group, P.C. to release any medical information necessary to process this claim.

DATE: _____ NAME: _____

SIGNATURE: _____

If the patient is a minor, the below signed represents the patient's legal guardian or parent:

DATE: _____ NAME: _____

SIGNATURE: _____



**Patient Acknowledgement
Receipt of Privacy Notice**

I, _____ hereby affirm that a copy of the *Notice of Privacy Practices* from **Ross Eyecare Group, P.C.** has been presented to me and a copy is available upon request. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have been presented with a copy of the *Notice* and a copy is available upon request, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Signature of Patient or Legal Guardian

Date

Name of Patient or Legal Guardian