

Ridgefield Family Eye Care
Dr. Donald Teig, Dr. Alan Berman, Dr. Eric Bran

WELCOME!
Our Mission

To provide the highest level of professional eye care in a friendly and caring environment and to maximize the quality of life of our patients. To utilize the most advanced technology and professional skills. To inspire confidence through patient education.

Mr. Mrs. Ms. Dr. _____
First Name. MI Last Name Date

Street Address City State Zip

Social Security Number _____ Date of Birth _____ Age _____ M F

(Area Code) Home Phone (Area Code) Work Phone (Area Code) Cell Phone

Email Address Spouse or Parent(s) Name

Person Responsible for Account (Must Sign at bottom) _____

School / Employer _____ Grade/ Occupation _____

How will you settle your account today?
__ Cash __ Check __ Credit Card

How did you hear of our office?

Referral (Name) _____

Other _____

Primary Insurance Information:

Name and Address of Primary Insurance Company City State Zip

Insured's First Name Middle Initial Insured's Last Name

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

Patient Relationship to Insured

Patient Status

Self Spouse Child Other

Single Married Other
 Employed Full Time Student Part Time Student

Vision Insurance:

Aetna Blue Cross Medicare Oxford VSP Other _____

What is the main reason for today's exam? _____

When was your last exam? _____

Current Medications (RX or over the counter)

Antihistamine _____ Blood Pressure Pills _____

Diuretic (water pill) _____ Oral Contraceptives _____

Sleeping Tablets _____ Eye Drops _____

Others _____

Allergies to Medications: _____

Do You Experience...

- | | | |
|--|---|--|
| Glare or Reflection <input type="radio"/> Yes <input type="radio"/> No | Soreness <input type="radio"/> Yes <input type="radio"/> No | Sudden Loss of Vision <input type="radio"/> Yes <input type="radio"/> No |
| Sensitivity to Light <input type="radio"/> Yes <input type="radio"/> No | Itchiness <input type="radio"/> Yes <input type="radio"/> No | Fainting or Dizziness <input type="radio"/> Yes <input type="radio"/> No |
| Eye Strain <input type="radio"/> Yes <input type="radio"/> No | Redness <input type="radio"/> Yes <input type="radio"/> No | Flashes of Light <input type="radio"/> Yes <input type="radio"/> No |
| Headaches <input type="radio"/> Yes <input type="radio"/> No | Gritty Feeling in Eyes <input type="radio"/> Yes <input type="radio"/> No | Nausea <input type="radio"/> Yes <input type="radio"/> No |
| Trouble Seeing at Night <input type="radio"/> Yes <input type="radio"/> No | Blurry Distance Vision <input type="radio"/> Yes <input type="radio"/> No
(With Glasses or Contact Lenses) | Other : _____ |
| Burning <input type="radio"/> Yes <input type="radio"/> No | Blurry Near Vision <input type="radio"/> Yes <input type="radio"/> No
(With Glasses or Contact Lenses) | _____ |
| Dryness <input type="radio"/> Yes <input type="radio"/> No | Double Vision <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Watery Eyes <input type="radio"/> Yes <input type="radio"/> No | Objects Floating in Vision <input type="radio"/> Yes <input type="radio"/> No | |

Visual Needs: Do you...

- Work at a computer? Yes No
- Want information on thinner, lighter contact lenses? Yes No
- Want information on lineless bifocals? Yes No
- Spend lots of time outdoors? Yes No
- Are you experiencing any problems with your glasses/contact lenses? Yes No
- Have only one pair of glasses? Yes No
- Find that your eyes are sensitive to sunlight? Yes No
- Do you work in an environment that requires wearing safety glasses? Yes No

Would you be interested in information on Lasik Surgery? Yes No

Would you be interested in a Non-Surgical alternative to Lasik? Yes No

Family Medical History...

- | | |
|--|---|
| Blindness <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No |
| Heart Disease <input type="radio"/> Yes <input type="radio"/> No | Eye Diseases <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Other _____ |

Patient Medical History:

- | | | |
|--|--|--|
| Allergies <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Fainting or Dizziness <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis <input type="radio"/> Yes <input type="radio"/> No | Heart Disease <input type="radio"/> Yes <input type="radio"/> No | Other _____ |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Cataracts <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Nerves <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Skin Disorder <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Eye Injury <input type="radio"/> Yes <input type="radio"/> No | Nausea <input type="radio"/> Yes <input type="radio"/> No | |
| Eye Surgery <input type="radio"/> Yes <input type="radio"/> No | | |

Social History:

This information is kept strictly confidential. However, you may discuss this portion with your doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

- Yes No I would prefer to discuss my Social History directly with my doctor.
- Yes No Do you use tobacco products?
- Yes No Do you have a dependency on any drug/alcohol substance?

Patient Questionnaire

1. What is your primary form of vision correction? Glasses Contact Lenses None
2. What are the occasions when you do Not want to wear your glasses?
Sports _____ Business _____
Physical Fitness _____ Other _____
Social / Hobby _____
3. What is it about your contact lenses that you would like improved?
(i.e. end of day comfort, dry eye, better vision, etc.) _____
4. How would you prefer to wear contact lenses?
 Occasionally Everyday Have not considered
5. Have you worn contact lenses in the past, but are no longer wearing them?
 Yes No Does not apply
a. If Yes, how long ago? _____ b. What type? Rigid Soft
6. Why did you stop wearing contact lenses? (check all that apply)
 Cost / Too Expensive Inconvenient / lens care hassle
 Uncomfortable Did not want to wear them all the time
 Prefer to wear glasses Other _____
7. Do you have astigmatism? Yes No Do not know
8. Do you require bifocals? Yes No Do not know

I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations. In addition, I give my permission for your office to leave telephone messages confirming appointments and any other related office matters.

Patient Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient _____ Print Name _____

Professional fees are due when services are rendered unless prior arrangements are made. A deposit of 50% is required towards the total cost of glasses before an order can be placed. The remaining balance is due at the time of dispensing. When eyeglasses are purchased through insurance, the balance is due in full when order is placed. When ordering contact lenses, total payment is due before order can be placed, unless otherwise specified. Thank you for your cooperation.