Ridgefield Family Eye Care

Dr. Alan Berman, Dr. Eric Bran, Dr. Rachel Hawran

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

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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:

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Name and Address of Primary Insurance Company City State Zip

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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

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ 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? ______________________________

<u>Current Medications (RX or over the counter)</u>

☐ Antihistamine ______________________ ☐ Blood Pressure Pills ______________________

☐ Diuretic (water pill) ______________________ ☐ Oral Contraceptives ______________________

☐ Sleeping Tablets ______________________ ☐ Eye Drops ______________________

☐ Others ____

Allergies to Medications: ____

Do You Experience...

Glare or Reflection ◯ Yes ◯ No
Sensitivity to Light ◯ Yes ◯ No
Eye Strain ◯ Yes ◯ No
Headaches ◯ Yes ◯ No
Trouble Seeing at Night ◯ Yes ◯ No
Burning ◯ Yes ◯ No
Dryness ◯ Yes ◯ No
Watery Eyes ◯ Yes ◯ No

Soreness ◯ Yes ◯ No
Itchiness ◯ Yes ◯ No
Redness ◯ Yes ◯ No
Gritty Feeling in Eyes ◯ Yes ◯ No
Blurry Distance Vision ◯ Yes ◯ No
(With Glasses or Contact Lenses)
Blurry Near Vision ◯ Yes ◯ No
(With Glasses or Contact Lenses)
Double Vision ◯ Yes ◯ No
Objects Floating in Vision ◯ Yes ◯ No

Sudden Loss of Vision ◯ Yes ◯ No
Fainting or Dizziness ◯ Yes ◯ No
Flashes of Light ◯ Yes ◯ No
Nausea ◯ Yes ◯ No
Other : ____________________

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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 ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No
Heart Disease ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No

High Cholesterol ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No
Eye Diseases ◯ Yes ◯ No
Other ____________________

Patient Medical History:

Allergies ◯ Yes ◯ No
Arthritis ◯ Yes ◯ No
Asthma ◯ Yes ◯ No
Cataracts ◯ Yes ◯ No
Cancer ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No
Eye Injury ◯ Yes ◯ No
Eye Surgery ◯ Yes ◯ No

Glaucoma ◯ Yes ◯ No
Heart Disease ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No
Nerves ◯ Yes ◯ No
Skin Disorder ◯ Yes ◯ No
Nausea ◯ Yes ◯ No

Fainting or Dizziness ◯ Yes ◯ No
Other ____________________

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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

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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.