Welcome to Our Office

Please fill out this patient data sheet so that we may better understand your general health and visual condition.

Patient Information

Date: _____

❑ Dr.
❑ Mr.
❑ Miss

Name ❑ Mrs. _____ Date of Birth _____ Male/Female

Last First MI

Home Address _____ Social Security Number _____

City _____ State _____ Zip _____

Preferred Number _____ Home/Cell (circle one)

Employer _____ Present Position _____

Business Address _____ Business Phone _____

Marital Status: Married / Single / Divorced / Widow Email (optional)_____

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White

Language:_____ Ethnicity: Hispanic or Latino
Not Hispanic or Latino

Person Responsible for Billing (If other than patient)

❑ Dr.
❑ Mr.
❑ Miss

Name ❑ Mrs. _____ Date of Birth _____ Male/Female

Last First MI

Home Address _____ Social Security Number _____

City _____ State _____ Zip _____

Preferred Number _____ Home/Cell (circle one)

Employer _____ Present Position _____

Business Address _____ Business Phone _____

If Using Spouse's Insurance:

❑ Dr.
❑ Mr.

Spouse's Name ❑ Mrs. _____ DOB _____ SSN _____

Please read and sign below

Insurance: We do accept assignment from most major insurance programs. Please present your insurance forms and any other information to the receptionist. If we have a benefits schedule on file for your company, we will accept assignment for that portion of your bill.

Assignment Permission: I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or any insurance administration provided any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for covered services to the physician or organization to submit a claim under the insurance program made either to me or to, Jeffrey D. Rice, O.D. or Slade S. Galloway, O.D. I understand that I am responsible for any deductible, co-insurance, or balance not paid by the insurance company. In the event that the claim is rejected or unreasonably delayed for any reason, I understand that I am responsible for the entire amount.

X _____

*** Please Complete Back Side**

I have read and understand the above.

Family Physician: _____

Last Eye Exam: _____

Complaint/Reason for visit: _____

Have you been seen by an Ophthalmologist? Where/Who: _____ **When?** _____

What For? _____

Please circle if applies and elaborate if possible

Medical History:

Hypertension	Heart Disease	Cancer	Diabetes
Thyroid Disorder	Acid Reflux	Arthritis	Neurological Disorder
High Cholesterol	Sinus Problems	Stroke	Psychiatric Disorder

Other: _____

Current Medications: _____

_____

Allergies to Medication: Penicillin / Sulfa / Steroids / Tetracycline / Thimerosal / Other: _____

Ocular History: Glasses Contacts Lazy eye Dry Eye Cataract Glaucoma Macular Degeneration

Other: _____

Previous Eye Surgery **(Y / N)** Explain: _____

Family History/Relationship: Diabetes_____ Heart Disease_____ Hypertension_____

Thyroid disease _____ Cancer _____ Other: _____

Cataracts _____ Glaucoma _____ Macular Degeneration_____

Other: _____

Environmental Allergies: Seasonal / Dust / Molds / Pet / Latex / Other: _____

Headaches: Mild / Moderate / Severe- How Often? _____ History of Migraine **(Y / N)**

Vision Related **(Y / N)** Associated with any other activities? _____ Any Pattern? _____

Front / Sides / Back of head - Time of day: _____ Does anything help? _____

Do your eyes: Itch / Burn / Water / Feel Dry / Feel Gritty / Experience Redness: _____ How Often? _____

Tobacco use: Y / N / Formerly

Alcohol use: Y / N / Social Use