

# 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

- Dr.  
 Mr.  
 Miss  
 Mrs.

Date: \_\_\_\_\_

Name	Last	First	MI	Date of Birth	M/F
Home Address				Social Security Number	
City				State	Zip
Home Phone Number				Cellular Phone Number (optional)	
Employer				Present Position	
Business Address				Business Phone	

Marital Status: Married / Single / Divorced / Widow

## Person Responsible for Billing (If other than patient)

- Dr.  
 Mr.  
 Miss  
 Mrs.

Name	Last	First	MI	Date of Birth	M/F
Home Address				Social Security Number	
City				State	Zip
Home Phone Number				Cellular Phone Number (optional)	
Employer				Present Position	
Business Address				Business Phone	

## If Using Spouse's Insurance:

- Dr.  
 Mr.  
 Mrs.

Spouse's Name	DOB	SSN
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## 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 \_\_\_\_\_  
**I have read and understand the above.**

\* Please Complete Back Side

**Primary Care Physician:** \_\_\_\_\_

**Complaints/Reason for visit:** \_\_\_\_\_

*Please circle if applies and elaborate when possible*

**Medical History:**                      Diabetes                      Hypertension                      Heart Disease  
Breathing Problems                      Head Injuries                      Thyroid Problems  
Sinus Problems                      Other: \_\_\_\_\_

**Medications currently taking:** \_\_\_\_\_

**Ocular History:**                      Glasses                      Contacts                      Lazy Eye  
Eye Surgery                      Other: \_\_\_\_\_

**Family History:**                      Diabetes                      Heart Disease                      Lung Disorders  
Other: \_\_\_\_\_  
Glaucoma                      Cataracts                      Macular Degeneration  
Blindness                      Other: \_\_\_\_\_

**Seasonal Allergies:** Spring / Summer / Autumn / Winter / Other: \_\_\_\_\_

**Allergies to Medications:** Penicillins / Sulfa / Steroids / Tetracyclines / Thimerosal / Other: \_\_\_\_\_

**Environmental Allergies:** Dusts / Molds / Pets / Other: \_\_\_\_\_

**Headaches:** Mild / Moderate / Severe, How often: \_\_\_\_\_

Vision Related (Y / N) Associated with any other activities: \_\_\_\_\_

Front / Sides Back of Head, Time of Day:                      Does Anything help? \_\_\_\_\_

**Do your eyes:** Itch / Burn / Water / Feel Gritty / Experience Redness: \_\_\_\_\_

**General Surgical Procedures?:** \_\_\_\_\_

**Tobacco use?** Y / N / Formerly

**Alcohol use?** Y / N / Social use