MEDICAL VS. VISION

Patient:_____ Date of Birth: _____ Date:_____

Is this a Routine refractive or Medical eye examination?

Routine Vision (Refractive) Coverage: Your **"vision"** insurance is intended to provide you with a baseline eye evaluation and **update your glasses prescription only.** If the doctor discovers a medical eye problem during a routine exam, the doctor will inform you that your visit is now a medical exam and will be billed to your medical insurance. You can choose to finish the routine examination and return at a later date for the medical exam or you can choose to have a routine and medical exam today.

Medical Eye Examination Coverage: If you have an eye condition such as but not limited to: cataracts; macular degeneration; glaucoma; diabetes; dry eyes; cornea problems, this examination will be billed to your medical insurance.

Patient Responsibilities: Many insurance companies do not pay for a routine eye examination. Many private insurance plans do pay for annual eye examinations. **If your insurance company does not pay for routine eye exams, you will be charged a self- pay charge for your examination.** It is your responsibility to check with your insurance carrier for proper coverage and to let us know before your eye examination. Please understand that each patient's insurance coverage varies and **Rittenhouse Eye Associates** cannot be held responsible for knowing every patient's coverage.

- I am here for a: (circle one) **Routine Refractive** **Medical Exam**
- Do you wear Contacts or Glasses? _____
- Are you experiencing any eye problems or do you have any known eye diseases?

_____

_____

- Do you have vision coverage such as: VSP, Davis, VBA, March Vision, EyeMed, Other _____
- **If you are here for a medical exam, and want a refraction for glasses and do not have routine eye coverage a $30.00 fee will be required at the time of check in.**
- Do you have medical coverage? YES NO (Plan Name) _____

_____ _____

Patient or Guardian Signature Date

_____

Relationship if not signed by patient

NEW PATIENT REGISTRATION

Revised September 2017

PLEASE PRINT

NAME: Mr. Mrs. Ms. Dr. (circle title) _____

MARITAL STATUS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

CELLULAR PHONE: _____

WORK PHONE: _____

E-MAIL ADDRESS _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MEDICAL DOCTOR & PHONE #: _____

HOW DID YOU HEAR ABOUT RITTENHOUSE EYE ASSOCIATES? (CIRCLE ALL THAT APPLY)

FRIEND/ CO-WORKER HEALTH PLAN INTERNET DOCTOR AD OTHER

IF YOU HEARD ABOUT THE PRACTICE THROUGH A SPECIFIC PERSON, PLEASE WRITE THEIR NAME. _____

INSURANCE COVERAGE, IF ANY: _____

INSURANCE # (IF APPLICABLE): _____

SUBSCRIBER'S NAME (IF DIFFERENT FROM SELF): _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

EMERGENCY CONTACT PERSON: _____

EMERGENCY CONTACT PERSON PHONE NUMBER: _____

YOUR LIFETIME RELEASE AND AUTHORIZATION AND PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

"I request that payment of the authorized Medicare (AND Medigap) benefits or authorized health insurance benefits be made to Rittenhouse Eye Associates for any services furnished me by any physician associated with Rittenhouse Eye Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, or any health insurance program to which I am a member any information needed to determine these benefits or the benefits payable for related services. I also acknowledge that I have been given a copy of the Notice of Privacy Practices"

X PATIENT'S (OR GUARDIAN'S) SIGNATURE: _____

DATE: _____

Date _____

Name _____ **Sex** M F
First Middle Last

Date of Birth _____ **Age** _____

Your Past Medical History

Known **Medical Conditions** (ex: Diabetes, High Blood Pressure, High Cholesterol, Arthritis…etc)

_____

_____

Have you had any **injuries**? Y N If yes, what type _____

Have you ever been **hospitalized**? Y N If yes, date/reason _____

Have you had any **surgery**? Y N If yes, date/type _____

Do you have a history of **cancer**? Y N If yes, what type _____

List of **Medications** (Prescription & Over the Counter)

_____

_____

List of Known **Allergies**

_____

Primary Care Physician _____ Date of Last Visit _____ Date of Next Visit _____

Review of Systems

To ensure a more thorough health exam, please inform us if you have any problems in any of the areas listed below.

(Please check EACH box)

	Yes	No
Eyes:		
Blurred Vision- Distance	☐	☐
Blurred Vision- Near	☐	☐
Itching	☐	☐
Burning/Tearing	☐	☐
Pain in/around Eyes	☐	☐
Discharge from Eyes	☐	☐
Seeing Spots/Floaters	☐	☐
Seeing Flashes/Lights	☐	☐
Glare/Increased Light Sensitivity	☐	☐
Ear, Nose, Throat		
Sinus Congestions	☐	☐
Chronic Cough	☐	☐
Dry Mouth	☐	☐
Hearing Loss	☐	☐
Neurologic		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Numbness/Tingling	☐	☐
Multiple Sclerosis	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Genitourinary		
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Sexually Transmitted Disease	☐	☐
Are you/Could you be pregnant?	☐	☐

	Yes	No
Constitutional		
Fever	☐	☐
Weight Loss/Gain	☐	☐
General Malaise/Fatigue	☐	☐
Cardiovascular		
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid	☐	☐
Respiratory		
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
Gastrointestinal		
Heart Burn	☐	☐
Abdominal Pain	☐	☐
Constipation/Diarrhea	☐	☐
Integumentary		
Rashes	☐	☐
Eczema	☐	☐
Acne Rosacea	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Bipolar	☐	☐

PLEASE TURN OVER →

Family History

(Living or deceased relatives who are related to you by blood- i.e. siblings, parents, grandparents, children)

Disease/Condition	**Yes**	**No**	**Relationship to you**
Blindness	☐	☐	
Glaucoma	☐	☐	
Crossed/Lazy Eye	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment	☐	☐	
Retinitis Pigmentosa	☐	☐	
Other Eye Problems_____	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Sickle Cell	☐	☐	
Cancer	☐	☐	
Other _____	☐	☐	

Your Social History

Occupation _____

Do you **smoke**? Y N If yes, how many cigarettes/packs a day_____

Do you **drink alcohol**? Y N If yes, how many drinks/week_____

Do you use any **recreational drugs**? Y N If yes, which one(s) _____

Your Past Ocular History

Known **Eye Conditions** (ex: Glaucoma, Cataract, Retinal Detachment, "Lazy Eye")

_____

_____

Previous Eye Doctor _____ Date of Last Visit _____

Have you ever had:

Eye Surgery? Y N _____

Eye Injury? Y N _____

Are you currently using any **eye drops**? Y N

If yes, which drop(s)_____

How many times/day_____

Reviewed by: _____ **Date** _____

Doctor's Signature

Vision Needs Questionnaire

(Please circle all that apply)

1. Do you currently wear glasses? Y N If so, how old are they? _____
   If so, what type of glasses?
   Distance Vision Only
   Drug Store Reading Glasses
   Bifocals with a line
   Progressives- No Line Bifocals
   Other _____

2. How often do you wear your Glasses?
   All the time
   Only for reading
   Only for Driving
   Other_____

3. Do you suffer from unsatisfactory vision/eye strain?
   Distance
   Intermediate (i.e. Computer)
   Near-reading

4. How many hours are you in front of the computer? 0-1 Hour 2-4 Hours 5+ Hours

5. How many hours do you spend reading? 0-1 Hour 2-4 Hours 5+ Hours

6. Do you suffer from glare?
   Daytime Only
   Night Time Only
   Day and Night

7. Do you wear contact lenses? Y N
   If so, are you happy with the vision? Y N
   Are you happy with the comfort? Y N
   Do you sleep in your contacts? Y N If yes, how many nights/week? _____
   How often are you replacing your lenses (every month/week/day) _____
   Brand/Name of contacts _____ Base Curve _____
   Prescription for Right Eye _____ Prescription for Left Eye _____