PATIENT HISTORY

Name: _____ Date: _____

Medications – List all medications you are currently taking

Name of Medication Dosing Reason Prescribed

_____
_____
_____
_____
_____

Over-the-counter medications / vitamins

_____
_____

Allergies – Do you have any allergies to medications? _____ YES _____ NO

If so, list medications and type of reaction: _____
_____
_____

PERSONAL MEDICAL HISTORY

Do you have any of the following illnesses? And if so, year diagnosed.

			YEAR				YEAR
Diabetes	YES	NO		Syphilis	YES	NO	
Glaucoma	YES	NO		Hypertension	YES	NO	
Macular Degeneration	YES	NO		Kidney Disease	YES	NO	
Lupus	YES	NO		Arthritis	YES	NO	
Thyroid Disease	YES	NO		Cancer	YES	NO	
Stroke	YES	NO		Heart Disease	YES	NO	
Multiple Sclerosis	YES	NO		Emphysema	YES	NO	
Asthma	YES	NO		Tuberculosis	YES	NO	
HIV Positive	YES	NO		Hepatitis	YES	NO	

List any other major illnesses _____
_____

List any Surgeries (including **eye surgery**) or operations that you have had and the year they occurred

_____
_____

Symptoms: Check any of the following symptoms you are currently experiencing

EYES

Blurred Vision	YES	NO	Blind Spots	YES	NO
Floaters	YES	NO	Flashing Lights	YES	NO
Distortion of Vision	YES	NO	Fluctuating Vision	YES	NO
Double Vision	YES	NO	Loss of Peripheral Vision	YES	NO
Light Sensitivity	YES	NO	Poor Night Vision	YES	NO
Tunnel Vision	YES	NO			

EARS / NOSE / THROAT

Congestion	YES	NO	Hearing Problems	YES	NO
Sores or lesions in mouth	YES	NO	Lumps or nodes in neck	YES	NO
Jaw pain while chewing	YES	NO			

HEART

Irregular Heart Beat	YES	NO	Chest Pain	YES	NO
Fainting spells	YES	NO	Swelling in legs	YES	NO

SKIN

Rashes	YES	NO	Redness / Sores	YES	NO

CHEST

Shortness of breath	YES	NO	Wheezing	YES	NO
Cough	YES	NO			

HEMATOLOGICAL

Excessive Bleeding	YES	NO

GASTROINTESTINAL

Abdominal Pain	YES	NO	Blood or pus in stools	YES	NO
Diarrhea	YES	NO			

BONES AND JOINTS

Joint Pain, Swelling, redness	YES	NO	Back Pain, Stiffness	YES	NO

GENITOURINARY

Pain with urination	YES	NO	Blood in urine	YES	NO
Genial sores or lesions	YES	NO	Urgency or Frequency	YES	NO
Unexplained weight loss	YES	NO	Night Sweats	YES	NO

NEUROLOGICAL / PSYCH

Weakness	YES	NO	Headaches	YES	NO
Trouble Speaking / swallowing	YES	NO	Depression / Anxiety	YES	NO
Forgetfulness	YES	NO	Incoordination	YES	NO
Numbness	YES	NO			

FAMILY HISTORY

These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in the **family** had / has :

Glaucoma	YES	NO	Diabetes	YES	NO
Blindness / Poor Vision	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Stroke	YES	NO
Hypertension	YES	NO	Cataracts	YES	NO

SOCIAL HISTORY

What is your present weight? _____

What is your present height? _____

What is your current occupation? _____

Do you drive?	YES	NO
Is driving a necessity for you?	YES	NO
Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Have you ever smoked? Year quit:	YES	NO
Have you ever used intravenous (street) drugs?	YES	NO

Signature _____ Date _____

PATIENT HISTORY

ID # _____
(Office use)

Name: _____ Date: _____

Medications – List all medications you are currently taking

Name of Medication Dosing Reason Prescribed

_____
_____
_____
_____
_____

Over-the-counter medications / vitamins

_____
_____

Allergies – Do you have any allergies to medications? _____ YES _____ NO

If so, list medications and type of reaction: _____
_____
_____

PERSONAL MEDICAL HISTORY

Do you have any of the following illnesses? And if so, year diagnosed.

			YEAR				YEAR
Diabetes	YES	NO		Hypertension	YES	NO	
Macular Degeneration	YES	NO		Glaucoma	YES	NO	
Cancer	YES	NO		Stroke	YES	NO	
Lupus	YES	NO		Arthritis	YES	NO	
Heart Disease	YES	NO		Lung Disease	YES	NO	
Kidney Disease	YES	NO		Hepatitis	YES	NO	
Multiple Sclerosis	YES	NO		Thyroid Disease	YES	NO	
Tuberculosis	YES	NO		HIV Positive	YES	NO	

List any other major illnesses _____

_____

List any Surgeries (including **eye surgery**) or operations that you have had and the year they occurred

_____

_____

Symptoms: Check any of the following symptoms you are currently experiencing

EYES

Blurred Vision	YES	NO	Blind Spots	YES	NO
Floaters	YES	NO	Flashing Lights	YES	NO
Distortion of Vision	YES	NO	Fluctuating Vision	YES	NO
Double Vision	YES	NO	Loss of Peripheral Vision	YES	NO
Light Sensitivity	YES	NO	Poor Night Vision	YES	NO
Tunnel Vision	YES	NO			

EARS / NOSE / THROAT

Congestion	YES	NO	Hearing Problems	YES	NO
Sores or lesions in mouth	YES	NO	Lumps or nodes in neck	YES	NO
Jaw pain while chewing	YES	NO			

HEART

Irregular Heart Beat	YES	NO	Chest Pain	YES	NO
Fainting spells	YES	NO	Swelling in legs	YES	NO

SKIN

Rashes	YES	NO	Redness / Sores	YES	NO

CHEST

Shortness of breath	YES	NO	Wheezing	YES	NO
Cough	YES	NO			

HEMATOLOGICAL

Excessive Bleeding	YES	NO

GASTROINTESTINAL

Abdominal Pain	YES	NO	Blood or pus in stools	YES	NO
Diarrhea	YES	NO			

BONES AND JOINTS

Joint Pain, Swelling, redness	YES	NO	Back Pain, Stiffness	YES	NO

GENITOURINARY

Pain with urination	YES	NO	Blood in urine	YES	NO
Genial sores or lesions	YES	NO	Urgency or Frequency	YES	NO
Unexplained weight loss	YES	NO	Night Sweats	YES	NO

NEUROLOGICAL / PSYCH

Weakness	YES	NO	Headaches	YES	NO
Trouble Speaking / swallowing	YES	NO	Depression / Anxiety	YES	NO
Forgetfulness	YES	NO	Incoordination	YES	NO
Numbness	YES	NO			

FAMILY HISTORY

These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in the **family** had / has :

Glaucoma	YES	NO	Diabetes	YES	NO
Blindness / Poor Vision	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Stroke	YES	NO
Hypertension	YES	NO	Cataracts	YES	NO

SOCIAL HISTORY

What is your present weight? _____

What is your present height? _____

What is your current occupation? _____

Do you drive?	YES	NO
Is driving a necessity for you?	YES	NO
Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Have you ever smoked? Year quit:	YES	NO

Have you ever used intravenous (street) drugs?	YES	NO

Signature _____ Date _____

Date of Birth _____

ID # _____
(Office Use)

PATIENT HISTORY

Name: _____ Date: _____

PERSONAL MEDICAL HISTORY

Do you have any of the following illnesses? And if so, year diagnosed.

			YEAR				YEAR
Arthritis	YES	NO		Asthma	YES	NO	
Cancer	YES	NO		Cholesterol	YES	NO	
Diabetes	YES	NO		Emphysema	YES	NO	
Glaucoma	YES	NO		HIV Positive	YES	NO	
Heart Disease	YES	NO		Hepatitis	YES	NO	
Kidney Disease	YES	NO		Lupus	YES	NO	
Multiple Sclerosis	YES	NO		Stroke	YES	NO	
Thyroid Disease	YES	NO		Tuberculosis	YES	NO	
Glaucoma	YES	NO		Macular Degeneration	YES	NO	

List any other major illnesses _____

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List any Surgeries (including **eye surgery**) or operations that you have had and the year they occurred

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Flashing Lights	YES	NO	Fluctuating Vision	YES	NO
Floaters	YES	NO	Loss of Peripheral Vision	YES	NO
Light Sensitivity	YES	NO	Poor Night Vision	YES	NO
Tunnel Vision	YES	NO			

EARS / NOSE / THROAT

Congestion	YES	NO	Hearing Problems	YES	NO
Sores or lesions in mouth	YES	NO	Lumps or nodes in neck	YES	NO
Jaw pain while chewing	YES	NO			

HEART

Irregular Heart Beat	YES	NO	Chest Pain	YES	NO
Fainting spells	YES	NO	Swelling in legs	YES	NO

SKIN

Rashes	YES	NO	Redness / Sores	YES	NO

CHEST

Shortness of breath	YES	NO	Wheezing	YES	NO
Cough	YES	NO			

HEMATOLOGICAL

Excessive Bleeding	YES	NO

GASTROINTESTINAL

Abdominal Pain	YES	NO	Blood or pus in stools	YES	NO
Diarrhea	YES	NO			

BONES AND JOINTS

Joint Pain, Swelling, redness	YES	NO	Back Pain, Stiffness	YES	NO

GENITOURINARY

Pain with urination	YES	NO	Blood in urine	YES	NO
Genial sores or lesions	YES	NO	Urgency or Frequency	YES	NO
Unexplained weight loss	YES	NO	Night Sweats	YES	NO

NEUROLOGICAL / PSYCH

Weakness	YES	NO	Headaches	YES	NO

Trouble Speaking / swallowing	YES	NO	Depression / Anxiety	YES	NO
Forgetfulness	YES	NO	Incoordination	YES	NO
Numbness	YES	NO			

FAMILY HISTORY

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Has anyone in the **family** had / has:

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Blindness / Poor Vision	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Stroke	YES	NO
Hypertension	YES	NO	Cataracts	YES	NO

SOCIAL HISTORY

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What is your present height? _____

What is your current occupation? _____

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Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Have you ever smoked? Year quit:	YES	NO
Have you ever used intravenous (street) drugs?	YES	NO

Medications – List all medications you are currently taking

Name of Medication Dosing Reason Prescribed

_____
_____
_____
_____
_____

Over-the-counter medications / vitamins

_____
_____

Allergies – Do you have any allergies to medications? _____ YES _____ NO

If so, list medications and type of reaction: _____
_____

_____

Signature _____ Date _____

Patient Information

Patient Name _____ Date _____

Do you reside in a care facility? Yes No

Name of Preferred Pharmacy _____

Address, Cross streets, or City & phone number

_____

Please list the name of your:

Primary Care Physician _____

General Ophthalmologist (eye doctor)_____

Optometrist (glasses) _____

Other physician _____

Language Preference

- English
- Spanish
- French
- Japanese
- Other _____

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic / Latino
- Middle Eastern
- Native Hawaiian or other Pacific Islander
- Caucasian
- Other _____

Ethnicity

- Hispanic or Latino
- Non Hispanic or Latino

RCSC Financial Policies

Our practice is committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide Medical and Surgical Ophthalmological care to our patients, as opposed to routine eye exams. We do not participate with any vision plans. Therefore, if you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit at its conclusion.

If there is any change in your coverage and we were not notified prior to your visit, then you will be responsible for all incurred fees.

Any claim denies by your insurance will be transferred to patient responsibility. Your co-pay amount may differ based on the level of service/care you have received. Any additional charges will be your responsibility. We will send a statement for all balances due after your insurance carrier has reviewed and paid/denied your claim. All balances are your responsibility and we appreciate a prompt remittance.

It is the patient's / parent's / guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all current insurance cards to each of your visits.
- Provide our office with current information including address, phone numbers, employee and primary care physician information.
- In accordance with your insurance contract you must be prepared to pay your co-pay at the time of your visit. We accept cash, checks, major credit cards and CareCredit. If you do not pay your co-pay at the time of your visit, you will be billed an additional $10 service fee.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify our billing department immediately and we will try to work out a payment option. ALL RETURNED CHECKS ARE SUBJECT TO A $35 service fee.

For all services rendered to minor/dependent patients, we will look to the accompanying adult/parent for financial reimbursement. When presenting insurance cards for a dependent enrolled under another subscriber, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform them that their insurance has been used. All co-pays and co-insurance fees are due at the time of service and will not be billed to a third party.

□ I have read and understand the above financial policy.

Name of patient _____
Name of guarantor _____

Signature of guarantor _____

Relationship _____

Date _____