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As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this information in order to give you the best care possible.

- **Completed Welcome to the Office Form :** This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.
- **Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a “ whole person” rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication, which may be brought in as a separate list for us to photocopy if you prefer.
- **Insurance cards or claim forms:** For any optical and/or medical insurance you may be covered by. (Even for “routine” visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination.)
- **Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.
- **Contact Lenses:** It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacturer, etc.
- **Eye drops, ointments, etc:** Please place any eye drops or ointments that you use in a small bag and bring it along with you. Your doctor will review whether these are appropriate or if a better option is available.
- **Dilation Explained:** The doctor may need to use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing “fuzzy” vision at a near (reading) distance. Therefore, if you want new eyewear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection.

Completing the task list for the items that apply to you will assure you of receiving most thorough and professional care possible and in a very efficient manner.

We look forward to your visit !!!

EYECARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Or _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

3 PHONE NUMBERS

Home _____ Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home Phone _____

4 REASON FOR VISIT

I AM INTERESTED IN:

- Glasses
- Contact Lenses
- Laser Vision Correction
- Other _____

5 EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam? _____

Name of doctor _____

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|----------------------------|--|--------------------------|--|
| Bloodshot Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Itching Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light Sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge from Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Halos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Flashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Twitching Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valva	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant? _____	Number of children _____			
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco use _____	Alcohol use _____			

MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____

Date _____