Ramona Eye Care Optometry
1662 Main Street, Ste. B
Ramona, CA 92065

WELCOME TO OUR OFFICE

Patient Information

Last _____
First _____ MI _____
Mailing Address _____
City _____
State _____ Zip Code _____
Home Phone _____
Cell Ph _____ Texting? ❑ Yes ❑ No
Date of Birth _____ Age _____ Sex M F
Email Address _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Emergency Contact Person _____
Phone _____

What is the main purpose of this visit?

_____

Do you notice any problems with your current contact lenses or glasses? _____

Whom may we thank for referring you to our office?
Name of friend or relative _____
Another Doctor's referral, Dr. _____
If not referred, how did you choose our office?
❑ Insurance List ❑ Saw Sign/Building
❑ Newspaper
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Mission Statement

Our office is dedicated to providing our patients with the highest quality, professional eye care available. We are committed to helping our patients maintain quality vision throughout their lifetime with thorough eye health exams and providing patient education. We strive to offer the newest advancements in contact lens and eyewear products to help you attain excellent vision and address all your lifestyle needs with warm and friendly service to exceed your highest expectations.

Eyewear Policy

We allow 90 days following your Comprehensive Eye Exam to return for any glasses related follow-up visits at no charge. After 90 days, a $45 refraction fee will apply for glasses related issues. A new Eye Exam is required after 6 months from your initial visit. By state law, Glasses Prescriptions expire two years from your last complete eye exam; Contact Lens Prescriptions expire one year from your last exam.

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Medical Insurance _____ ❑ PPO ❑ HMO
Policy Number _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a FSA or HSA? ❑ Yes ❑ No

Patient Eye & Lifestyle History

Date of Last Eye Exam _____
By Whom? _____

Have you ever had any injuries or surgeries in your eyes?
❑ **Yes** ❑ **No** If so, what kind/ when? _____

_____

Are you experiencing any of the following?

❑ Blurry Vision	❑ Burning Sensation
❑ Double Vision	❑ Flashes of light
❑ Floaters/Spots	❑ Headaches
❑ Itchy Eyes	❑ Grittiness
❑ Watery Eyes	❑ Light Sensitivity

Have you ever been diagnosed or treated for any of the following?

❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Glaucoma
❑ Macular Degeneration	❑ Lazy Eye
❑ Iritis/ Uveitis	❑ Retinal Detachment

❑ Other eye disorders _____

Do you……(check box if your answer is yes)
❑..work at a computer/e-device? How many ____ hrs/day?
❑..have prescription sunwear?
❑..spend time outdoors? How much? ____Hrs/week
❑..have problems driving at night?
❑..think you might benefit from thinner, lighter lenses?
❑..want information on Laser Vision Correction surgery?
❑..have special eyewear needs (safety, sports, etc.)

Please list your Hobbies: _____

_____

GLASSES:
Do you currently wear glasses? ❑ Yes ❑ No
❑ Single Vision ❑ Progressive ❑ Bifocal ❑ Trifocal

OVER PLEASE⟶

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List medications including eye drops, vitamins, & birth control pills) ❑ **None**_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Do you drink alcohol? ❑ Yes ❑ No How often?_____

Do you smoke? ❑ Yes ❑ No How often?_____

Do you use other drugs or illicit substances? ❑ Yes ❑ No

Women - Are you pregnant or nursing? ❑ Yes ❑ No

Please list any past surgeries: _____

_____

Have you been diagnosed or treated for the following health problems? ❑ **None**

❑ Cardiovascular Problems ❑ High Blood Pressure
❑ High Cholesterol ❑ Blood/ Lymph
❑ Digestive ❑ Genitourinary
❑ Migraine Headaches ❑ Shingles
❑ Allergies; What kind? _____
❑ Constitutional (Fevers, Fatigue, Unusual weight loss/gains)
❑ Ears/Nose/Throat infections _____
❑ Endocrine (Thyroid, Kidney) _____
❑ Diabetes; Insulin/Non-Insulin How many years? _____
❑ Cancer; What kind? _____
❑ Eczema/Rashes/ Skin Conditions _____
❑ Muscle/Bone (Arthritis, Fibromyalgia) _____
❑ Neurological (MS, Epilepsy) _____
❑ Psychological (Depression, Anxiety) _____
❑ Respiratory (Asthma, Bronchitis) _____

Contact Lenses

Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____
Are you interested in being (re)evaluated for contact lenses today?* ❑ Yes ❑ No
Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

*The Contact Lens Evaluation is a separate annual service fee. It includes checking the fit and vision of your contact lenses, diagnostic lenses, and contact-lens related follow up visits for up to 90 days. This service is sometimes covered by your insurance as a benefit in lieu of glasses. Fees range from $60 to $225 depending on your prescription and eye health needs. After 90 days, there is an additional charge of $45 for a contact lens refit, and you will have an additional 90 days of contact lens related follow up visits.

I have read and understand the contact lens evaluation fee: _____ (Patient/ parent initials)

Family Medical History

Is there a family history of any of the following:

	Relationship (Parent, Sibling, etc.)
Corneal Problems	❑_____
Amblyopia/Lazy Eye	❑_____
Glaucoma	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____
Diabetes	❑_____
Heart Disease	❑_____
Cancer	❑_____
High Blood Pressure	❑_____
Other	❑_____

Acknowledgment of Patient Responsibility and Receipt of Notice of HIPAA Privacy Policies

I authorize treatment necessary, including such medicine, drugs, performance of duty or other studies that may be used by the physician or his/her assistants. I authorize my photo to be taken for inclusion in my medical record.
I authorize Ramona Eye Care Optometry to release any information necessary to process my claims for benefits, and give lifetime authorization for payment directly to this office for medical, vision, or surgical services rendered.
I acknowledge full responsibility for the payment of all services and agree to pay for them at the time of treatment unless other arrangements have been made. If my insurance does not reimburse the office in full within 90 days, I agree to be responsible for payment. I understand my account may be turned over to a collection agency in the event that I do not make my payments.

Please be advised that a copy of our HIPPA policy is posted in our office, or is available by photocopy to all our patients. Please ask our staff if you would like a copy of our Privacy Policy today. I acknowledge that I understand the policies and have been made available a copy of Ramona Eye Care Optometry's Notice of Privacy Policies.

I approve of messages for appointments to be left with a family member or answering machine.
I approve of mail and/or email such as postcards with appointments, requested information, or newsletters.

Patient Name_____ **Signature** _____ **Date**_____

If patient is a minor, sign by Parent or Guardian _____ Name_____