PATIENT HISTORY

Are you here for: **Glasses exam** _____ **Contacts** ____ **Other Reason** ________________________

Name____ **Male** ________ **Female** ______

Address____ **Date of Birth** ___________________

City_____________________ **State** _______ **Zip** _______

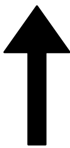
List ALL insurances ____________________________ **How much is your co-pay?** ________

Are you the Primary Insured or are you a family member? ____ **Primary** ____ **Family member (spouse / child)**

Home Phone: ______________________________

Cell Phone: ______________________________

Email:___________________________________



We're **online**! **Confirm** your appointments via text or email! Your **email** is the only way we will send you a yearly reminder (not for soliciting)

Which of our offices was your last appointment?

Skibo / Hope Mills / Raeford / Ramsey / Yopp

Marine / Hendersonville / Ft. Bragg / Other

Office Name: __________________________

I know my HIPAA rights: ____ Yes

Personal Medical

Race:______________________________

Family Doctor _______________________(______Never ____ Don't remember) **Last Visit:** _______________

Last Eye Doctor____________________(______Don't have one) **Last Eye Exam**______________________

What problems are you having today (check all that apply):

Are these problems noticed with your glasses / contact on or off? _____**On** ____ **Off** ______**Both**

What	**Location**	**Duration**	**Timing**	**Context**	**Severity**
____Blur at distance	____Both eyes	____Minutes	____Constant	____While driving	____Mild
____Blur at near	____Right eye	____Hours	____Intermittent	____School board	____Moderate
____Blur everywhere	____Left eye	____Days		____Reading book	____Severe
____Diabetic Ret.		____Months		____Computer	
____Glaucoma		____Years		____Other	
____Macular Degen		____All my life			
____Cataract					
____Dry					
____Itch					
____Pain					

Does anything make it better? **No** ___ **Yes, what?** ______________________________

Other information you wish to provide:

____

____

____

____

Review Of Systems (If we are filing insurance for you, your insurance company requires a complete history to be filled out. Please do not leave any question blank.) This Section Applies to YOU and YOUR Family Members

NO (X)		Yes (X)	Who	Explain
_______	Diabetes	__________	________	____
_______	Heart	__________	________	____
_______	Ear /Noses	__________	________	____
_______	Lungs	__________	________	____
_______	Stomach	__________	________	____
_______	Urinary	__________	________	____
_______	Skin	__________	________	____
_______	Nervous	__________	________	____
_______	Psychiatric	__________	________	____
_______	Weakness	__________	________	____
_______	Blood	__________	________	____
_______	Allergies	__________	________	____
_______	Other	__________	________	____
_______	**Pregnant**	__________	ME	How far along are you?_____________________
	Eye Diseases			
_______	Glaucoma	__________	________	____
_______	Cataract	__________	________	____
_______	Macular Deg	__________	________	____
_______	Eye Injury	__________	________	____
_______	Retina	__________	________	____
_______	Blindness	__________	________	____
_______	Turned eye	__________	________	____
_______	Lazy eye	__________	________	____

Anything Else?____

Social History (Gives us an idea of your visual needs and is required by most insurance companies)

Do you smoke?_____ **PPD**?_______**Years**?________ **Recreational Drugs**?________________________________

How much Alcohol do you consume?______________ **What is your OCCUPATION**?________________________

What are your HOBBIES?____

Have you had any major surgeries? When?____

MEDICATIONS:____

ALLERGIES:____

Please Note: Insurance may cover part of your charges, or may be payable directly to you. Please give any forms to the receptionist. If your insurance company does not pay as expected, you are ultimately responsible for the charges.

I have read my privacy rights. I understand I may request a copy. I authorize the release and payment of any medical or other information necessary to process claims filed pertaining to services rendered at this office. **I understand and agree that the professional services provided to me are nonrefundable. Method of payment today must be in cash or credit card. We no longer accept checks.**

A service charge of 1 ½ % per month, 18% APR will be added to overdue accounts. Also liable for legal and collection fees.

Signature ____ **Date**___________________________

Insurance Sponsor's Name ______________________________ **I.D.#**___________________________

RISK OPTOMETRIC
ASSOCIATES, PA

INSURANCE INFORMATION

In order to process your claim to the insurance provided, additional information may be needed. Please fill out this form to the best of your ability so your claim can be processed properly.

Patient's Name____

Plan Name____

Sponsor's / Primary's Name:________________________________

Sponsor's / Primary's Date of Birth__________________________

Sponsor's / Primary's SS#__________________________________

Sponsor's / Primary's Gender: ______**Male**

______**Female**

Sponsor's / Primary's Employer______________________________

REQUEST FOR NON-COVERED SERVICES

I am hereby requesting that the following services be provided to me by ______________________________

(Provider Name)

Services (list all)	Frequency Limitations	Proposed Date(s) of Service	Estimated Cost of Service

In making this request, I acknowledge that these services are not a benefit of my health coverage with ___________________________. In addition I acknowledge that if I obtained service(s) more frequently than authorized by my insurance policy, I may be responsible for that professional service(s).

I also understand that if my insurance company has denied authorization for this care, or if reimbursement is denied upon submittal of a claim form. I may appeal the written notification of the denial issued by my insurance company.

Unless the decision to deny is overturned as a result of an appeal or dispute, I agree that I will be personally responsible for the payment **In Full** of the billed charges for these services.

Patient's Name (please print)____

Patient Signature____

Date____