FOUNDERS EYE CARE

Dr. Joseph J Raffa, O.D., COVD **Dr. Reggie L Ragsdale, O.D.**

Patient Name: _____
DOB: _____ **SSN:** _____ **Sex:** M / F
Address: _____
_____
City, State, Zip: _____
_____
Email: _____
Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____
Employment: FULL TIME/PART TIME/RETIRED/NOT EMPLOYED **Student:** FULL TIME / PART TIME
Marital Status: Single Married Divorced Widowed

Vision/Medical Insurance: _____ **ID Number:** _____
_____
Primary Policy Holder: _____
SSN: _____ **DOB:** _____
Relationship to Patient: _____

Date of last exam? _____ _
Do you smoke? **Yes** **No** **Quit** **Never**
Do you drink alcohol? **Yes** **No** **occasionally**
Height? _____ Weight? _____
Are you pregnant or nursing? _____

Do you currently wear glasses: Yes / No **Contact Lenses:** Yes / No
Reason for visit today: Glasses, Contact Lenses, Lasik, Other: _____

Please circle all that apply to your eyes:

Redness/Burning/Itching Watery Discharge (mucus/milky) Pain/Soreness Eyestrain/Eye Fatigue
Doubling Loss of Place when Reading Covers one eye Reading Glare Light Sensitivity
Flashes/Floaters Sandy/Gritty Foreign Body Sudden or Night Vision Loss
Other: _____

MEDICAL HISTORY:

Do you or anyone in your ***immediate*** *family* (to include parents, siblings, maternal and paternal grandparents, aunts, and uncles) *have any of the following?*

	You	Family		You	Family		You	Family
Allergies	____	____	Heart Disease	____	____			
Anxiety/ Depression	____	____	Diabetes	____	____	Hypertension	____	____
			Cataracts	____	____	High Cholesterol	____	____
Arthritis	____	____	Cancer	____	____	Thyroid	____	____
Asthma	____	____	Macular Degeneration	____	____	Glaucoma	____	____
						Retinal Tears	____	____

MEDICATIONS YOU ARE TAKING (to include eye drops):

_____
_____
_____
_____

MEDICATION ALLERGIES:

_____
_____

INSURANCE BILLING POLICY AND ACKNOWLEDGMENT

Our office has agreed to bill the insurance company provided to us and accept payment on your behalf. Information we provide to you is based upon information given to us by your insurance carrier. This information is not a guarantee of payment by your insurance company. In the event that payment is not received, the patient is then responsible for payment.

Patient Name: _____

Signature: _____ Date: _____