Ross Eyecare Group, P.C.
Welcome To Our Office

Welcome to Ross Eyecare Group, P.C.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Cell Phone

Email Address | Spouse or Parent(s) Name | Person Responsible for Account (Must sign at bottom)

Height ft in cm/m ◉ ft in ○ cm ○ m

Weight ◉ lbs ○ kg

☐ Caucasian
☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian Or Other Pacific Islander
☐ Other Race
☐ Native American
☐ Not Disclosed
☐ White

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐
☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Patient (Please Name) _____
☐ Doctor (Please Name) _____

Primary Insurance Information

Name and Address of Primary Insurance Company or Routine Vision Provider | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

Secondary Insurance Information

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts
90 days old are subject to collection fees. There will be a service charge on all returned checks.
Payment from my insurance is to be paid directly to Ross Eyecare Group, P.C.. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Signature

Name

Ross Eyecare Group, P.C.

PATIENT HISTORY AND INFORMATION

Dr. _____ _____ _____
Primary Care Provider | Name Of Provider's Office | Phone Number

VISUAL HISTORY

Current Occupation : _____ Years _____ Employer _____

Do you use a computer ? ○ Yes ○ No How many hours/day _____ Distance from Computer _____

Do you drive? ○ Yes ○ No Mileage to work each way _____ Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses ? ○ Yes ○ No Reason for stopping _____

Do you currently wear contact lenses ? ○ Yes ○ No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort :	_____	_____	Distance Vision :	_____	_____	Near Vision :	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SPECTACLE LENS HISTORY

Do you currently wear glasses ? ○ Yes ○ No Since _____

Use of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned

☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses ? ○ Yes ○ No Are your sunglasses your current prescription ? ○ Yes ○ No

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Hobbies/ Interests : _____

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

Name

Ross Eyecare Group, P.C.

MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

Headaches	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Lazy Eye	○ Yes	○ No	Double Vision	○ Yes	○ No
Burning	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Dryness	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Excess Tearing/Watering	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Eye Pain or Soreness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Foreign Body Sensation	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No
Infection of Eye or Lid	○ Yes	○ No	Redness	○ Yes	○ No
Itching	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No
Mucous Discharge	○ Yes	○ No	Crossed Eyes	○ Yes	○ No

GENERAL HEALTH CONDITION

Fever	○ Yes	○ No	Kidney	○ Yes	○ No
Weight Loss	○ Yes	○ No	Muscles,Bones,Joints	○ Yes	○ No
Other Consti. Symptoms	○ Yes	○ No	Skin	○ Yes	○ No
Ears,Nose,Throat	○ Yes	○ No	Neurological (MS)	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Anxiety, Depression, Insomnia	○ Yes	○ No
Respiratory (Asthma)	○ Yes	○ No	Diabetes,thyroid	○ Yes	○ No
Gastrointestinal	○ Yes	○ No	Blood/Lymph (cholesterol)	○ Yes	○ No
Psychiatric	○ Yes	○ No	Allergic/Immunologic	○ Yes	○ No

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

if yes, who?

Lazy Eye	○ Yes	○ No	Arthritis	○ Yes	○ No
Blindness	○ Yes	○ No	Cancer	○ Yes	○ No
Cataract(s)	○ Yes	○ No	Diabetes	○ Yes	○ No
Color Blindness	○ Yes	○ No	Heart Disease	○ Yes	○ No
Glaucoma	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Lupus	○ Yes	○ No
Eye Turn	○ Yes	○ No	Stroke	○ Yes	○ No
			Thyroid Disease	○ Yes	○ No
			Others	○ Yes	○ No

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ➢ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ➢ Obtaining payment from third party payers (e.g. my insurance company);
- ➢ The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Ross Eyecare Group, P.C.
2625 Piedmont Road NE
Atlanta, GA 30324

INSURANCE RESPONSIBILITY

I, the undersigned, understand that I am ultimately responsible for payment in full for all charges incurred by me at Ross Eyecare Group, P.C. If my insurance company does not pay for services rendered or materials furnished by Ross Eyecare Group, P.C., or if for any reason my deductible has not been met, it is my responsibility to pay the usual and customary fees for said services and materials. I also realize that I am responsible for any co-payment and deductible required under my insurance. If this matter becomes a collection matter, I will assume all attorneys' fees, collection costs, and court costs incurred by Ross Eyecare Group, P.C. in its attempt to collect any and all outstanding debt on my account.

I authorize Ross Eyecare Group, P.C. to release any medical information necessary to process this claim.

DATE: _____ NAME: _____

SIGNATURE: _____

If the patient is a minor, the below signed represents the patient's legal guardian or parent:

DATE: _____ NAME: _____

SIGNATURE: _____