C EYE CARE

Cynthia Ragland, OD
236 N. 13th Street
Marshalltown, Iowa 50158
Phone: 641-352-3544
Fax: 641-352-3547

Patient Demographics

Name: Last	First	M.I.	Nickname	
Address:		City	State	Zip
DOB:	Social Security Number:		Sex: M or F	
Home Phone:	Cell:		Work:	
Email Address:				
Employer:		Position:		
Medical Insurance:	Policy Number	Policy Holder:	Policy Holder's D.O.B.:	S.S.#:
Vision Insurance:	Policy Number	Policy Holder:	Policy Holder's D.O.B.:	S.S.#:
Marital Status:	Spouse:	D.O.B.:		
Emergency Contact:	Relationship:		Emergency Phone:	

How may we communicate with you
❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email ❑ Text Message ❑ Mail ❑ All Of The Preceding

Is it okay to leave a message on your voice mail or answering machine? ❑ **Yes** ❑ **No**

How did you hear about our office?

❑ Friend ❑ Relative ❑ Another Dr. ❑ Referred by _____ ❑ Previous Patient of Dr. Ragland

❑ Web Site ❑ Facebook ❑ Newspaper ❑ Walk-in ❑ Insurance Listing

PRIVACY PRACTICES ACKNOWLEDGMENT AND INSURANCE PAYMENT AUTHORIZATION

I acknowledge that I have received a copy of the Notice of Privacy Practices of C Eye Care to review. I also authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry for goods or services rendered. I permit a copy of this authorization to be used in place of the original signature and authorize release of medical information necessary to pay the claim. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred, and that payment is expected at the time of service or at the time of ordering. If I have Medicare, I understand that my signature requests payment of authorized Medicare benefits be made on my behalf to C Eye Care, for any goods/services furnished to me by that physician/supplier.

Name: _____ **Signature:** _____ **Date:** _____
(Print) **(Parent/Guardian if under 18)**

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WELCOME TO OUR OFFICE

Name: Date:

What is the main reason for this visit?

Date of last exam? By whom? How old is your current eyewear?

Do you wear contacts? * ❑ Yes ❑ No What brand?

How often do you replace your contacts? Do you sleep in your contacts? ❑ Yes ❑ No

DO YOU EXPERIENCE? HAVE YOU BEEN DIAGNOSED OR TREATED FOR? (CHECK BOX FOR YES)

❑ Blurry Vision	❑ Grittiness	❑ Cataracts	❑ Eye Injury	❑ Glaucoma
❑ Burning Eyes	❑ Itchy Eyes	❑ Diabetic Retinopathy	❑ Tearing	❑ Blepharitis
❑ Headaches	❑ Light Sensitivity	❑ Macular Degeneration	❑ Dry Eye Disease	❑ Flashes of Light
❑ Poor Night Vision	❑ Retinal Detachment	❑ Double Vision	❑ Floaters/Spots	❑ Lazy Eye

HAS ANYONE IN YOUR FAMILY BEEN TREATED FOR...

Glaucoma ❑ _____ Diabetes ❑ _____ Lazy Eye ❑ _____

Macular Degeneration ❑ _____ High Blood Pressure ❑ _____ Other (Please Specify) ❑ _____

PERSONAL HEALTH HISTORY

Family Physician: _____ Clinic: _____ Date of Last Physical: _____

Pharmacy: _____

Are you taking any prescription medications? ❑ Yes ❑ No List _____

Are you taking non-prescription medications? ❑ Yes ❑ No List _____

Do you have allergies? ❑ Seasonal ❑ To Medicine(s) Please Identify _____

Do you use? Alcohol ❑ Yes ❑ No Cigarettes/Tobacco ❑ Yes ❑ No

Have you had any eye surgeries? ❑ Yes ❑ No Type of surgery _____ Date _____

HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING HEALTH PROBLEMS? If yes, please explain.

Constitutional (developmental disability, fever, weight loss, fatigue)	❑ Yes	❑ No	_____
Ear/Nose/Throut/Mouth (hearing loss, URT infection)	❑ Yes	❑ No	_____
Neurological (multiple sclerosis, epilepsy)	❑ Yes	❑ No	_____
Psychological (depression, anxiety)	❑ Yes	❑ No	_____
Cardiovascular (heart, high blood pressure, stroke)	❑ Yes	❑ No	_____
Respiratory (asthma, sleep apnea)	❑ Yes	❑ No	_____
Gastrointestinal (Crohn's, colitis, ulcer, digestive)	❑ Yes	❑ No	_____
Genitourinary (kidney dysfunction, prostrate/ovarian cancer)	❑ Yes	❑ No	_____
Muscles/Joints (osteoarthritis, weakness)	❑ Yes	❑ No	_____
Skin (eczema, rosacea, rash, dryness)	❑ Yes	❑ No	_____
Endocrine (diabetes, hyper-or hypo-thyroid)	❑ Yes	❑ No	_____
Blood (anemia, leukemia)	❑ Yes	❑ No	_____

*** To all contact lens wearers: you will be responsible for the charges for your contact lens evaluation.**

**** All contact lens prescriptions must be finalized within 90 days of your initial examination.**