OREGON TRAIL EYE CENTER, PC

PATIENT INFORMATION *Please PRINT In BLACK Ink*

Patient ID# _____

Patient's Name: _____ (First / Initial / Last) **Date of Birth:** _____ **Age:** _____

Social Security #: _____ **Sex:** ◯M ◯F **Marital Status:** ◯Married ◯Single ◯Divorced ◯Widowed

Mailing Address: _____ **City, State, Zip:** _____

E-mail Address: _____ **County:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

May we leave a message at your home or cell number? **Yes** ◯ **No** ◯

Occupation: _____ **Employer:** _____ **Phone:** _____

Referring Physician: _____ **Personal/Family Physician:** _____

Spouse's Name: _____

RESPONSIBLE PARTY INFORMATION *(If different than above)*

Responsible Party: _____ **Patient Relationship:** _____

Date of Birth: _____ **Social Security #:** _____

Address: _____ **City, State, Zip:** _____

Employer: _____ **Phone:** _____

EMERGENCY CONTACT *Please give name and phone number of a friend or relative that does not live at your present address.*

Name: _____ **Phone:** _____

Relationship: _____

Person(s) with who(m) we may share your healthcare information: _____

PRIMARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

_____ _____

Group Number **Certificate Number**

SECONDARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

_____ _____

Group Number **Certificate Number**

Insurance Authorization and Assignment **(PLEASE READ)**

I authorize Oregon Trail Eye Center, P.C. to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance companies and third party payers.

I request that payment of medical benefits be made on my behalf to the Oregon Trail Eye Center PC for any services provided to me by Dr. Thomas J. Roussel, Dr. Shawna R. Collier, Dr. Keegan A. Harkins or Dr. Brian L. Colburn. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other Health Care Organizations and it's agents any information needed to determine their benefits. I understand that if the balance is my responsibility.

I authorize treatment of the person named above, I CERTIFY THAT I AM THE PATIENT OR LEGAL GUARDIAN OF THE PATIENT, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable. All past due accounts will be charged 10% interest per year. The above information is for the purpose of extending credit and is warranted to be true.

X_____ **X**_____

Patient / Responsible Party Signature **Date**

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OREGON TRAIL EYE CENTER, PC

Patient Name: **DOB:**

Past Medical History

*Are you or have **ever** you been treated for:*

Diabetes	Y	N
High Blood Pressure	Y	N
Heart Disease (MI, irregular beat)	Y	N
Lung Disease (Asthma, COPD)	Y	N
GI/Colitis/Liver Disease	Y	N
Neuro Disease/Stroke	Y	N
Vascular Disease	Y	N
Arthritis	Y	N
Cancer	Y	N
Bleeding Disorder/Anemia	Y	N
HIV/AIDS/STD	Y	N
Kidney Disease/Dialysis	Y	N
Thyroid Disease	Y	N
High Cholesterol	Y	N

Past Surgical History:

Please list all past surgeries and/or injuries:

Oral Medications, including vitamins

Please list all medications; name, dosage, frequency:

(Use separate sheet of paper if needed)

Food, Drug, Other Allergies: *(Use separate sheet of paper if needed)*

Eye Disease/Surgery

Do you have or have you been treated for:

Retinopathy (Diabetes, Hypertension)	Y	N
Macular Degeneration	Y	N
Macular Edema	Y	N
Macular Hole	Y	N
Retinal Vein Occusion	Y	N
Vitreous Floaters	Y	N
Vitreous Hemorrhage	Y	N
Retinal Tear	Y	N
Retinal Detachment	Y	N
Cataract	Y	N
Glaucoma	Y	N
Infection	Y	N
Inflammation	Y	N
Strabismus/Amblyopia	Y	N
Dry Eyes	Y	N
Corneal Disease	Y	N

Other:_____

If yes, please explain (treatment, duration, surgery):

Eye Medications - *Please list name, dosage, frequency:*

(Use separate sheet of paper if needed)

Family and Social History - Do **any** medical or eye diseases run in your family? If Yes, please list & explain:

History of Tobacco use? Y N Type?_____ How Much? _____ Age quit?_____

Did you have the Influenza Vaccine this flu season (October 1st - March 31st)? Y N

Have you (in your lifetime) had pneumococcal vaccine? Y N

Have you had two or more falls in past year or any fall with injury in the past year? Y N

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Visual Assessment

Patient Name:_____ DOB: _____ Date:_____

1. **Does your vision with glasses make it a problem for you to:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Read Traffic signs	○	○	○
B. Drive during the daytime	○	○	○
C. Drive at night	○	○	○
D. See steps or curbs	○	○	○
E. Read labels on medicine bottles	○	○	○
F. Read a magazine/newspaper/book/phone	○	○	○
G. Watch television/use computer	○	○	○
H. Do household chores or hobbies (cooking, cleaning, sewing, cards, fine handiwork, etc)	○	○	○

2. **How much are you bothered by the following:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Walking outside on a sunny day	○	○	○
B. Driving towards the sun	○	○	○
C. Driving toward oncoming headlights (glare)	○	○	○
D. Seeing halo's around lights	○	○	○
E. Seeing in poor or dim light	○	○	○

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