❒ Dr. Tara H. Ransdell ❒ Dr. Jason T. Ransdell Room # ❒1 ❒2 ❒3

Patient Information (Provide legal name as it appears on your insurance)

Last name:	First:	Middle:	Birth date:

Address:

City State ZIP

❑ Student FT or PT
❑ Employed
❑ Retired
❑ Self

Marital status (circle one)

Single / Mar / Div / Sep / Wid

Home Phone: ( )

Mobile: ( )

Occupation: Age: Sex: ❑ M ❑ F

Reason for today's visit:

How did you hear about us?

Email Address:

Are you a new patient? ❑ Yes ❑ No

Whom may we thank for referring you?

Are you here for Routine Vision Exam? Yes / No

Are you here for a Medical Reason? Yes / No

Do you have Vision Insurance? ❑ Yes ❑ No ❑ Other

Name of Vision Insurance: VSP BCBS EyeMed Avesis Medicare Vision Care Direct Cigna Other:

Name of MEDICAL Insurance:

Name of Insured Member: Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other

Insured member's SS# Insured's Date of birth: / / Employer name:

Insurance ID# Group # Driver Lic #

PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you currently wear contact lenses? ❑ Yes ❒ No if you answered no, would you like to be fitted for contacts? ❑Yes ❑No

What kind of contact lenses do you currently wear? _____ Name of Contacts _____

Contact lens exams are in addition to routine eye exams and require a contact fitting. New fittings are $75, hard contact fittings are $120 and all others are $45. _____

Would you like your eyes dilated today? ❒ Yes ❒ No this is included with your eye exam at no extra cost. Initial

Do you currently wear glasses? ❒ Yes ❒ No if you answered yes, how old are they? _____ What type of lenses? _____

Hobbies: _____

Do you work on a computer? ❒ Yes ❒ No How many hours per day do you spend on the computer? _____

Do you have any allergies? ❒ Yes ❒ No _____

Medications you are currently taking: _____

_____

Diabetes	❒ Yes ❒ No ❒ Family	Lazy Eye	❒ Yes ❒ No ❒ Family	Macular degeneration	❒ Yes ❒ No ❒ Family
High Blood Pressure	❒ Yes ❒ No ❒ Family	Eye Surgery	❒ Yes ❒ No ❒ Family	Headaches	❒ Yes ❒ No ❒ Family
Cataracts	❒ Yes ❒ No ❒ Family	LASIK	❒ Yes ❒ No ❒ Family	Head/Eye injury	❒ Yes ❒ No ❒ Family
Glaucoma	❒ Yes ❒ No ❒ Family	Retinal Detachment	❒ Yes ❒ No ❒ Family	Heart problems	❒ Yes ❒ No ❒ Family
Loss of vision	❒ Yes ❒ No ❒ Family	Double Vision	❒ Yes ❒ No ❒ Family	Thyroid problems	❒ Yes ❒ No ❒ Family
Dry Eye	❒ Yes ❒ No ❒ Family	OTHER: _____			

If you are here for a medical reason other than a routine vision exam, please provide the front desk with a copy of your medical card and a photo ID. All medical visits are billed to your medical insurance and all non covered fees are the responsibility of the patient.

HIPAA Acknowledgement Form

I have received the Notice of Privacy Practices for my records and I have been provided the opportunity to review it. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non covered balance. I also authorize Peoria Eye Care and/ or my insurance company to release any information required to process my claims.

_____
Patient/Guardian signature

_____ _____ / _____ / _____
Print full name of patient Date