STEVEN E. RUHENKAMP, OD

PATIENT REGISTRATION FORM

DATE: _____

PATIENT: _____

ADDRESS: _____

_____

City State Zip

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

Do you prefer to be contacted by:
___ Phone (Home ____ Work_____ Cell _____)
___ US Mail

SEX: M_____ F_____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Occupation: _____

Are you a student? _____

Spouse/Partner Name: _____

Spouse Birthdate: _____

Spouse Occupation: _____

Spouse Employer: _____

Spouse Phone Number: _____

Whom may we thank for referring you?

_____

IN CASE OF EMERGENCY, CONTACT:
Name: _____
Relationship: _____
Phone Number: Home: _____
Work: _____ Cell: _____

Vision Insurance Information:

Policy Holder: _____

Relationship to Patient: _____
Policy Holder Birthdate: _____
Policy Holder SSN: _____
Insurance Company: _____
ID Number: _____
Group Number: _____

Medical Insurance Information:

Policy Holder: _____

Relationship to Patient: _____
Policy Holder Birthdate: _____
Policy Holder SSN: _____
Insurance Company: _____
ID Number: _____
Group Number: _____

Notice of Privacy Practices Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____
Patient Name

_____
Patient/Responsible Party Signature Date

FINANCIAL & INSURANCE AUTHORIZATION
HIPAA CONSENT

PATIENT NAME: _____ **DATE:** _____

AUTHORIZATION
I hereby give my consent to the doctors, staff, and associates of Steven E. Ruhenkamp, OD, to provide eye care services to myself and/or family. I understand and agree (regardless of my insurance status) that I am responsible for the balance of the account.

RESPONSIBLE PARTY SIGNATURE:_____DATE: _____

ASSIGNMENT AND RELEASE: (if patient has Insurance)
I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Steven E. Ruhenkamp, OD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

INSURANCE POLICY: (if patient has Insurance)
Changes made daily among insurance companies make it impossible to accept the responsibility of knowing if your plan dictates benefits, payment, coverage and whom you can and cannot see. As a service to you, we will file your insurance claim. In order for us to file your insurance, please provide all insurance information on the day of your visit. It remains the responsibility of the patient to know his or her own plan. The day of your exam, we require you to pay your copay and the exam if there is no insurance.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATION: (if patient has Medicare)
I request that payment of authorized Medicare benefits be made on my behalf to Steven Ruhenkamp, OD, for services furnished to me. I authorize any holder of medical information about me to be released to the Division of Medicare and Medicaid Services and its agents and any information needed to determine those benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE:_____ DATE: _____

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical care by Dr. Ruhenkamp. You hereby grant full authority to Dr. Ruhenkamp and respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to or upon you, which may be advised or necessary.

All health information may be shared with _____ RELATIONSHIP_____

PATIENT: _____ **DATE:** _____

SIGNED BY: _____ **RELATIONSHIP:** _____

WITNESS: _____
Steven E. Ruhenkamp, OD, Representative

STEVEN RUHENKAMP, OD
PATIENT MEDICAL HISTORY
DATE: _____

Patient Name (please print): _____ **Date of Birth:** _____

Vision:

Date of last eye exam: _____ Do you feel your vision is changing? _____
How many hours per day do you use a computer, tablet, or smart phone? _____
Do you currently wear: Glasses _____Yes _____ No Contacts _____Yes _____No
When did you last update your prescription? _____

Review of Systems:

Please circle the symptoms and/or conditions you currently have or have had in the past:

Constitutional:	Fever Sudden Weight Loss Sudden Weight Gain Fatigue
Cardiovascular:	Heart Disease High Blood Pressure Stroke High Cholesterol Irregular Heartbeat
Ear, Nose, Mouth, Throat:	Hearing Loss Nosebleeds Sore Throat Sinusitis Chronic Colds
Respiratory:	Asthma COPD Emphysema Shortness of Breath Bronchitis Sleep Apnea
Gastrointestinal:	Constipation Diarrhea Ulcers Heartburn
Genitourinary:	Frequent Urination Incontinence Bladder Infections Dialysis
Musculoskeletal:	Joint/Muscle Pain Arthritis Multiple Sclerosis
Integumentary:	Dermatitis Dryness Eczema Psoriasis
Neurological:	Epilepsy Headaches Migraines Seizures
Psychiatric:	Nervousness Depression Confusion Mood Swings
Endocrine:	Hypothyroid Hyperthyroid Diabetes (Type 1 Type 2)
Hematologic/Lymph:	Anemia Bleeding Disorders Lyme Disease
Allergy/Immunology:	Seasonal Allergies Redness Itching HIV

Cancer: Yes (type)_____ No

Patient/Family/Social History:

Please check the symptoms and/or conditions you currently have or have had in the past:

Eyes: __Glaucoma __Cataracts __Macular Degeneration __Eye Injury __Retinal Disease __Other Disease __Blindness __Lazy Eye (Strabismus) __Amblyopia __Diabetic Retinopathy __Dry Eye __Flashes/Floaters in Vision __Glare/Light Sensitivity __Excessive Tearing/Watering __Burning __Other:_____

Please note any family member with the following diseases/conditions:
(M-Mother, F-Father, S-Sibling, G-Grandparent)

__Glaucoma __Cataracts __Macular Degeneration __Retinal Disease __Other Disease __Blindness __Lazy Eye __Amblyopia __Diabetes __Cancer __Heart Disease __Hypertension __Other _____

Please indicate substances you use and consumption amount:
Alcohol: __Yes __No _____ drinks/week
Drugs: __Yes __No _____ times/week
Tobacco: __Yes __No _____ packs/day

Please indicate any hobbies or interests:
__Fishing/Hunting __Sewing __Golfing __Music __Reading __Sports __Other _____

STEVEN E. RUHENKAMP, OD

PATIENT MEDICAL HISTORY

DATE:_____

Patient Name: (please print) _____ **Date of Birth:**_____

Past Medical History:

Please list all past medical conditions, dates of hospitalizations and/or dates of anesthesia.

_____
_____
_____

Medications:

Please list all medications, including over-the-counter drugs, vitamins, or supplements.

_____
_____
_____

Please list all eye drops used, including artificial tears.

_____
_____

Allergies:

Please list all allergies, including medications and food or environmental allergies.

_____
_____

Primary Physician and Pharmacy Information:

Physician Name: _____
Address: _____
_____

Phone: _____
Fax: _____

Pharmacy Name: _____
Address: _____
Phone: _____

_____ _____ _____
Patient Signature Guardian Signature Date

_____
Doctor's Signature Date

For Doctor's Use:

Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____
Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____
Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____
Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____
Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____
Reviewed: _____/_____/_____ by _____ Reviewed _____/_____/_____ by _____