**RHODE EYELAND LLC**

Name: DOB:

Primary Care Physician:  When was your last physical? Pharmacy Name and Location:

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications, foods, latex, or dyes? What medical conditions do you have?

What medications or supplements are you taking?

## Do you smoke? Non-Smoker Former Smoker Current Smoker

## When did you start? When did you quit?

## Please circle all that apply:

Poor Vision Cough Rash/Hives Rapid Heartbeat Eye Pain Congestion Changing Moles Anemia Tearing Wheezing Allergies High Blood Pressure Red Eye Shortness of Breath Hay Fever Bleeding Temporary Vision Loss Headache Arthritis Fever/Chill Thyroid Abnormalities Jaw Pain Scalp Tenderness Joint Pain/Stiffness Diabetes Stuffy Nose Seizure Upset Stomach Insomnia Ear Ache Stroke Diarrhea Urinary Frequency Weight Loss Burning on Urination Paralysis Constipation Dry Mouth Anxiety Depression Incontinence

## Please indicate all that apply:

Allergic to Adhesives or Lidocaine? Yes or No

Using Blood Thinners or Flomax? Yes or No

Have a pacemaker, defibrillator, artificial joint or heart valve? Yes or No

Have you been exposed to or had Ebola or MRSA? Yes or No

Pregnant or planning to become pregnant? Yes or No

Are you pre-medicating for any upcoming surgeries? Yes or No

Have you received the Pneumonia Vaccination? Yes or No

Have you received the Influenza Vaccination this year? Yes or No

I am fully aware that I am responsible for all charges not covered by my insurance at today’s visit. This includes, but is ***not limited to:***

* Eye Examination
* Refraction
* Contact Lens Examination
* Any Screenings – including, but not limited to:
	+ Visual Acuity, Color Blindness, Amsler Grid, Pupillary Distance
* Any Testing – including, but not limited to:
	+ Auto-Refraction, OCT Scanning, Fundus Photography, Visual Field Testing
* Any Procedures or Treatments – including, but not limited to:
	+ Corneal Abrasions, Epilation, Punctal Plugs, Foreign Body Removal, Bandage or Therapeutic Contacts
* $50 charge for any missed appointments

Signature: Date: Relationship to patient: Self Parent Power of Attorney

Initial Here : \_\_\_\_\_\_\_\_\_\_\_\_ **I** **HAVE** PROVIDED A COPY OF MY INSURANCE CARD

 Initial Here: \_\_\_\_\_\_\_\_\_\_\_\_  **I** **HAVE NOT** PROVIDED A COPY OF MY INSURANCE CARD