



**Charles H. Rutan, O.D.**

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[www.advantageeyecare.org](http://www.advantageeyecare.org)

**( PLEASE PRINT )**

Miss, Ms., Mr., Mrs., Dr. \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel. ( ) - \_\_\_\_\_ Work Tel. ( ) - \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Your job (or grade) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Last Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_

Sex: M \_\_\_\_ F \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's) Work Phone ( ) - \_\_\_\_\_

Physician \_\_\_\_\_

Physician's Phone # ( ) - \_\_\_\_\_ Fax # ( ) - \_\_\_\_\_

<b>YOUR MEDICAL HISTORY</b>		
Allergies	No	Yes
Asthma	No	Yes
Skin Disorder	No	Yes
Eye Diseases	No	Yes
Eye Injury	No	Yes
Eye Surgery	No	Yes
Lazy Eye	No	Yes
Cataracts	No	Yes
Glaucoma	No	Yes
Arthritis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
High Blood Pressure	No	Yes
Kidney Disease	No	Yes
Nerves	No	Yes
High Fevers	No	Yes
Other		

<b>FAMILY MEDICAL HISTORY</b>			
	No	Yes	Relationship
Lazy Eye	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Other Eye Disease	No	Yes	_____

<b>CURRENT MEDICATIONS (Rx Or Over-the-Counter)</b>	
	Name of Medication
Antihistamines	_____
Diuretics (Water Pills)	_____
High Blood Pressure Pills	_____
Oral Contraceptives	_____
Sleeping Tablets	_____
Eye Drops	_____
Other	_____
Are you allergic to any medications: No Yes	
If yes please list below:	

Are you experiencing any of the following?

<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Skipping or repeating lines	<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Spots floating in vision
<input type="checkbox"/> Blurry near vision	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Burning	<input type="checkbox"/> Trouble reading or learning at work,
<input type="checkbox"/> Sudden loss of vision	<input type="checkbox"/> Reverse letters or words	<input type="checkbox"/> Gritty feeling in eyes	school, or activity
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Redness	<input type="checkbox"/> Glare or reflection	<input type="checkbox"/> Trouble remembering what is seen
<input type="checkbox"/> Double vision	<input type="checkbox"/> Soreness	<input type="checkbox"/> Dryness	
<input type="checkbox"/> Poor depth perception	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Poor eye-hand coordination	
Do you wear glasses? No Yes		Contact lenses? No Yes	

What is the major purpose of this visit? \_\_\_\_\_

Do you use a computer? \_\_\_\_\_ Hours per day? \_\_\_\_\_

How far away is the computer screen? \_\_\_\_\_

What other family members are Advantage Eyecare patients? \_\_\_\_\_

Do you have headaches? \_\_\_\_\_ Where? \_\_\_\_\_

When do they start? \_\_\_\_\_ Duration? \_\_\_\_\_

What helps? \_\_\_\_\_

Are you interested in laser vision correction?  Yes  No

Is there a history of headaches in your family? \_\_\_\_\_

**CONTINUED ON BACK**

Are your current glasses or contact lenses comfortable?  Yes  No

Have you ever worn or are you currently wearing contact lenses?  Yes  No

What kind? \_\_\_\_\_ Solutions Used \_\_\_\_\_

Are you interested in contact lenses?  Yes  No

If so are you interested in a free no-obligation contact lens "test drive?"  Yes  No

Would lenses that become darker outside be helpful to you?  Yes  No

Do you have more than one pair of current prescription glasses?  Yes  No

If you wear glasses, are you interested in thinner, lighter lenses?  Yes  No

Do you wear bifocals?  Yes  No

If so are you bothered by head-tilting, restricted areas of vision corrections, etc.?  Yes  No

Are there times you would rather not wear glasses?  Yes  No

How much time do you spend outdoors?  Yes  No

Do you have prescription sunglasses?  Yes  No

Are you bothered by glare or reflection, particularly when driving at night?  Yes  No

Do you participate in a flexible spending account at work?  Yes  No

Please list any hobbies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How will you settle your account today?

Check  Cash  Credit Card  Payment Plan

Vision Insurance \_\_\_\_\_

Medical Insurance \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Name of Insured Person \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ - - \_\_\_\_\_

Work Phone ( ) - \_\_\_\_\_

Home Phone ( ) - \_\_\_\_\_

Address \_\_\_\_\_

How did you first hear about Advantage Eyecare?

Referred by a friend or relative  
If so who? \_\_\_\_\_

Referred by another healthcare practitioner  
If so who? \_\_\_\_\_

Yellow pages...which directory?

Newspaper

Radio

Civic Group or Community Event  
If so which? \_\_\_\_\_

Office Signage

Vision Screening (at school or work)

Direct Mail

Other \_\_\_\_\_

**FINANCIAL POLICY**

The total professional fee, in addition to one half of all materials ordered (contact lenses, glasses, etc.), is asked for on the date the service is rendered. No material items can be dispensed without the entire balance being paid in full. Our office gladly accepts Visa, Mastercard, Discover, Debit cards, and Flex Spending cards.

Payment options are also available for any purchase made. Please feel free to inquire into these options.

Any account over 60 days old, will be subject to a late fee. Full collection proceedings will be utilized for any account aging to 90 days.

\_\_\_\_\_

Signature of financially person responsible

**PATIENT'S INSURANCE AUTHORIZATION**

I request that payment of authorized insurance benefits be made either to me or on my behalf of Advantage Eyecare for any services furnished to me by my doctor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration/Insurance Company and its agents any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. I also accept responsibility for any balance for services rendered.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_