INGRAM COMPREHENSIVE EYE CARE, PA
4406-A FOREST DRIVE COLUMBIA, SC 29206
(p) 803-782-7080 (f) 803-744-0964
www.ingrameyecare.com

DATE _____/_____/_____

**PATIENT DEMOGRAPHIC INFORMATION**

| LAST NAME ❒Mr ❒Ms ❒Mrs ❒Dr | FIRST NAME | MIDDLE | |
|---|---|---|---|
| HOME ADDRESS | CITY | ST | ZIP CODE |
| HOME PHONE | WORK PHONE | CELL PHONE | EMAIL ADDRESS |
| EMPLOYER (SCHOOL) | OCCUPATION (GRADE) | PREFERRED MEANS OF CONTACT: PHONE: ❒ HOME ❒ WORK ❒ CELL ❒ EMAIL ❒ OTHER__________ | |
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | |

**HOW DID YOU HEAR ABOUT OUR OFFICE?**

| | | | |
|---|---|---|---|
| ❒INSURANCE | ❒YELLOW PAGES | ❒OTHER__________ | ❒RELATIVE__________ |
| ❒AD__________ | ❒LOCATION | ❒FRIEND__________ | ❒DOCTOR__________ |

**IF PATIENT IS UNDER 18 YEARS OF AGE**

| NAME OF PARENT/GUARDIAN | RELATION TO PATIENT | HOME PHONE | CELL PHONE |
|---|---|---|---|
| | | | |

**MEDICAL INSURANCE COVERAGE**

| NAME OF MEDICAL INS. COMP. | POLICY HOLDER (IF DIFFERENT) | POLICY HOLDER DATE OF BIRTH | RELATION TO PAT. |
|---|---|---|---|
| GROUP NAME/ NUMBER | POLICY HOLDER SOCIAL SECURITY NUMBER | PHONE # | |

**VISION INSURANCE COVERAGE**

| NAME OF VISION INS. COMP. | POLICY HOLDER | RELATION TO PAT. |
|---|---|---|
| ID NUMBER | PHONE # | POLICY HOLDER DATE OF BIRTH |

PHARMACY NAME:
PHONE NUMBER:

***There is a separate fee for a contact lens exam. If you are interested in having a contact lens evaluation, please let us know so that we can research your insurance and answer any questions you may have regarding your coverage***

**I understand that I am financially responsible for all charges for services rendered, including the balance after payment of possible insurance benefits. I authorize payment of insurance benefits to the doctor. I understand Ingram Comprehensive Eye Care, PA. accepts and files for payment for services rendered as a courtesy and I understand it is my responsibility to supply all information needed. I acknowledge my understanding of my insurance coverage and I have been given the opportunity to ask questions about any charges that may be incurred today or in the furture regarding my eye care.**

**Patient/Guardian Signature**______________________________ Date_____/_____/_____

## MEDICAL INFORMATION (PLEASE CHECK ALL THAT APPLY)

| NAME OF PRIMARY CARE PHYSICIAN/GROUP | DATE OF LAST PHYSICAL | PHONE NUMBER |
|---|---|---|
| | | |

## DO YOU CURRENTLY:

WEAR GLASSES ☐Y ☐N AGE OF YOUR CURRENT GLASSES______
WEAR CONTACT LENSES ☐Y ☐N
CONTACT LENS BRAND:____________________________

## ARE YOU INTERESTED IN:

CONTACT LENSES T ☐ WEAR EVERYDAY
☐ ELIMINATE READING GLASSES
☐ WEAR SOCIALLY

## YOUR VISUAL FUNCTION

| | |
|---|---|
| WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING | ☐Y ☐N |
| SPEND TIME OUTDOORS | ☐Y ☐N |
| EYES ARE SENSITIVE TO SUNLIGHT | ☐Y ☐N |
| WOULD LIKE INFORMATION ON THINNER/LIGHTER LENSES | ☐Y ☐N |
| CONTACT LENSES GET DRY AT LEASET ONCE A DAY | ☐Y ☐N |
| CONTACT LENSES ARE NOT AS CLEAR AS YOU WOULD LIKE | ☐Y ☐N |
| HAVE PROBLEMS WITH GLARE OR REFLECTIONS | ☐Y ☐N |
| DO YOU SOMETIMES EXPERIENCE DRY EYES | ☐Y ☐N |

## HAVE YOU HAD:

☐ CATARACT SURGERY (R/L) ☐ EYE MUSCLE SURGERY ☐ RETINAL SURGERY ☐ LASIK/PRK SURGERY ☐ TRAUMATIC EYE INJURY

## VISION HISTORY

**F = father M = mother S = sibling GP = grandparent(s)**

| | You | FAMILY MEMBER |
|---|---|---|
| Amblyopia/Lazy Eye(s) | ☐ Y ☐ N | F M S GP |
| Blindness | ☐ Y ☐ N | F M S GP |
| Cataracts | ☐ Y ☐ N | F M S GP |
| Color Blindness | ☐ Y ☐ N | F M S GP |
| Crossed/Turned Eye(s) | ☐ Y ☐ N | F M S GP |
| Diabetic Retinopathy | ☐ Y ☐ N | F M S GP |
| Glaucoma | ☐ Y ☐ N | F M S GP |
| Herpetic Eye Disease | ☐ Y ☐ N | F M S GP |
| Keratoconus | ☐ Y ☐ N | F M S GP |
| Macular Degeneration | ☐ Y ☐ N | F M S GP |
| Retinal Detachment | ☐ Y ☐ N | F M S GP |
| Other Visual Disorders | ☐ Y ☐ N | F M S GP |

## SOCIAL HISTORY

DO YOU SMOKE ☐ NO ☐ YES PACKS PER DAY______
ALCOHOL USE ☐ NO ☐ YES DRINKS PER WEEK_____

## FEMALES: ARE YOU

☐ PREGNANT _____ MONTHS ☐ NURSING

## DRUG ALLERGIES

## LIST ALL CURRENT MEDICATIONS

## MEDICAL HISTORY - Do you or any of your blood relatives have:

**F = father M = mother S = sibling GP = grandparent(s)**

| | You | FAMILY MEMBER |
|---|---|---|
| **ALLERGY** | | |
| Environmental | ☐ Y ☐ N | F M S GP |
| Animal Dander | ☐ Y ☐ N | F M S GP |
| **CARDIOVASCULAR** | | |
| Elevated Cholesterol | ☐ Y ☐ N | F M S GP |
| Heart Disease | ☐ Y ☐ N | F M S GP |
| High Blood Pressure | ☐ Y ☐ N | F M S GP |
| **ENDOCRINE** | | |
| Diabetes | ☐ Y ☐ N | F M S GP |
| Thyroid Disorder | ☐ Y ☐ N | F M S GP |
| **GASTROINTESTINAL** | | |
| Acid-Reflux | ☐ Y ☐ N | F M S GP |
| Diverticulosis | ☐ Y ☐ N | F M S GP |
| **GENITOURINARY** | | |
| Kidney Stones | ☐ Y ☐ N | F M S GP |
| Sexually Trans. Disease | ☐ Y ☐ N | F M S GP |
| **HEMATOLOGIC/LYMPHATIC** | | |
| Anemia | ☐ Y ☐ N | F M S GP |
| Leukemia | ☐ Y ☐ N | F M S GP |
| Temporal Arteritis | ☐ Y ☐ N | F M S GP |
| **IMMUNOLOGIC** | | |
| Herpes Simplex | ☐ Y ☐ N | F M S GP |
| Herpes Zoster | ☐ Y ☐ N | F M S GP |
| HIV Positive | ☐ Y ☐ N | F M S GP |
| Sarcoidosis | ☐ Y ☐ N | F M S GP |

**F = father M = mother S = sibling GP = grandparent(s)**

| | You | FAMILY MEMBER |
|---|---|---|
| **INTEGUMENTARY** | | |
| Acne Rosacea | ☐ Y ☐ N | F M S GP |
| Ocular Roseacea | ☐ Y ☐ N | F M S GP |
| Fever Blisters/Colc | ☐ Y ☐ N | F M S GP |
| **MUSCULOSKELETAL** | | |
| Arthritis | ☐ Y ☐ N | F M S GP |
| Myasthenia Gravis | ☐ Y ☐ N | F M S GP |
| Osteoporosis | ☐ Y ☐ N | F M S GP |
| **NEUROLOGICAL** | | |
| Headache | ☐ Y ☐ N | F M S GP |
| Headache (migrain | ☐ Y ☐ N | F M S GP |
| **PSYCHIATRIC** | | |
| ADD | ☐ Y ☐ N | F M S GP |
| Anxiety Disorder | ☐ Y ☐ N | F M S GP |
| Depression | ☐ Y ☐ N | F M S GP |
| **RESPIRATORY** | | |
| Asthma | ☐ Y ☐ N | F M S GP |
| COPD | ☐ Y ☐ N | F M S GP |
| Lung Cancer | ☐ Y ☐ N | F M S GP |

**OTHER:**

## DIGITAL RETINAL PHOTOGRAPHY

We believe using the best technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Photography, which gives a high definition picture of your retina, interior blood vessels, and optic nerves. These images are vital in helping Dr. Ingram assess your risks for serious ocular diseases. The photos also serve as a very important baseline, so every year, your eyes can be compared to past images to monitor for even the smallest changes. I understand this procedure aides a comprehensive dilated eye exam but DOES NOT replace it.

❒ Yes, elect to have Digital Retinal Photography performed today (**additional fee $30, not covered by insurance**)
❒ No, against the advice of Dr. Ingram, I refuse Digital Retinal Photos and understand the health risks involved.

Patient/Guardian Signature______________________________________________ Date_____/_____/_____

## PATIENT INFORMED CONSENT FOR REFUSAL OF PUPIL DILATION

I understand Dr. Ingram recommends ocular dilation to more thoroughly evaluate the internal health of my eyes. I understand without dilation, serious diseases, such as diabetes, hypertension, retinal detachment, or malignant tumors (all can result in blindness, loss of either eye, or even death) could be present and not seen by the doctor. I understand there is not an alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless, and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions of Dr. Ingram, Ingram Comprehensive Eye Care, P.A. and their employees, officers, directors or agents.

Please check one:

________ I agree to be dilated today.

________ I will be responsible for rescheduling my dilation. If more than one week later, I understand an additional office visit fee will be charged.

________ I refuse the dilation.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*

I, ____________________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature ______________________________________________ Date_____/_____/_____

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained due to:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other: