

Ventura Eye Institute
Michael T. Ragen, M.D.

Date: _____

First Name: _____ Last Name: _____
Nickname: _____ Date of Birth: _____
Social Security #: _____ Male: ____ Female: ____
Marital Status: S__ M__ D__ W__ Address: _____ Apt. #: _____
City: _____ St: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____ ext. _____
Driver's Lic. #: _____ Email Address: _____
General Practitioner: _____ City _____
Last First
Who referred you to our office? _____

Financially Responsible (last, first): _____ Patient's relationship: _____
Address: _____ City: _____ St: _____ Zip: _____
Financially Responsible Phone #: _____ Work #: _____
Financially Responsible SSN: _____ DOB: _____

Insurance Information: (Please give insurance card(s) to the receptionist to copy)
Insurance Company: _____ Insured ID #: _____

Eye Problems:

- | | |
|---|--|
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Eyelid or eyeball lesions |
| <input type="checkbox"/> Flashes of light in either eye | <input type="checkbox"/> Lower eyelid drooping |
| <input type="checkbox"/> Itching/Burning in either eye | <input type="checkbox"/> Heavy upper eyelids |
| <input type="checkbox"/> Tearing or dryness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> History of glaucoma in your family | <input type="checkbox"/> Diabetes |

Have you ever had Laser Treatment? Y / N If yes, what type and which eye? _____
Have you had surgery on either eye? Y / N If yes, what kind of surgery? _____
Are you taking any medications? Y / N If yes, please list: _____
Are you allergic to any medications? Y / N **If yes, please list:** _____
List Prior surgeries and their dates: _____
Past medical history: _____

Financial/Insurance Agreement

By the signature below, I hereby certify the correctness of the above information and authorize release of information to my insurance company. I assign benefits to Ventura Eye Institute. A photocopy of the assignment may serve as the original. I hereby agree that in consideration for services rendered by the doctor, I shall make prompt payment to my account as bills are presented. If it becomes necessary for the account to be referred to a collective action, I shall pay the actual attorney's fees and collection expenses.

Signed: _____ Date _____
Patient or Responsible Party