FORSYTH
— EYE HEALTH AND SURGERY —
Susanna Ringeman, MD

Today's Date: _____

Appointment Date/Time: _____

Dear _____

Welcome to Forsyth Eye Health and Surgery!

We appreciate you trusting us for your eye health and surgical needs, and we look forward to meeting you soon.

To help prepare for your evaluation, here are a few things to consider for the day of your appointment.

Please note we are NOT affiliated with Atrium WFBH or Novant Health and will NOT have any information from your MyChart

Bring the following to your visit:

- Photo ID and all health insurance cards.
- **Completed Patient Information Forms.**
- A list of any medication and supplements including dosages (prescribed and over the counter).
- This visit is an evaluation of your eyes and we do not preform same day procedures.
- If you have eyeglasses or contact lenses (even if you no longer wear them) please bring them to your appointment (including contact lens boxes).

If you decide you would like a new glasses prescription, **a refraction fee of $65.00** is due at the time of service.

Additional information to consider for your upcoming visit... Please be prepared to pay your medical insurance deductible and/or copay at the time of service. Any unpaid visits due to invalid insurance will become the patient's responsibility.

Thank you again for choosing Forsyth Eye Health and Surgery. Our practice can only grow and improve with feedback from you, so please let us know how we are doing. We hope you have a wonderful experience, and if so, please do not hesitate to tell your friends about us! We look forward to seeing you soon!

Sincerely,

Dr Ringeman and Staff

2827 Lyndhurst Avenue, Suite 204, Winston-Salem, NC 27103
O: (336) 842-5477 F: (336) 602-2591 forsytheyehealth.com

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Name_____ Date of Birth (DOB)_____/_____/_____
Address_____
City_____ State_____ Zip Code_____
Social Security #_____ Email_____

Home_____ Cell_____ Marital Status_____
Spouse Name_____ Spouse Phone#_____

Employer_____ Occupation_____
Address_____
City_____ State_____ Zip Code_____

Hippa/Emergency Contact_____Relationship_____
Secondary Emergency Contact_____Relationship_____
Primary Phone #_____ Secondary Phone#_____

Primary Care Physician_____ Referred by_____
Pharmacy _____ Phone #_____
Address_____
City_____ State_____ Zip Code_____

Primary Insurance Company_____
Policy Holder_____Date of Birth _____/_____/_____
ID#_____ Group#_____ Relationship _____
Secondary Insurance Company_____
Policy Holder_____Date of Birth _____/_____/_____
ID#_____ Group#_____ Relationship _____

If you have Medicare, do either you or your spouse work full time? Yes or No

Do you wear glasses: **Y / N** Do you wear contact lenses: **Y / N** Date of last eye exam: _____/_____/_____
*** We do not prescribe contact lenses or fit glasses***

Do you use: Tobacco_____ Alcohol_____ Drug Use_____
Allergies: _____
Surgeries: _____

Medical History	Yourself	Family Member	Medical History	Yourself	Family Member
Glaucoma			Cancer		
Crossed or "Lazy" Eyes			Low Blood Pressure <100/60		
Macular Degeneration			Low Heart Rate <60 beats/min		
Retinal Detachment			Anemia (low blood count)		
High Blood Pressure			Migraine Headaches		
Diabetes			Sleep Apnea		
Heart Attacks/Disease			Raynaud's Phenomenon		
Stroke			Autoimmune Disease (i.e. Lupus, Rheumatoid Arthritis, HIV)		
Thyroid Disease					
Kidney Disease			Elevated Cholesterol		

Medication Name	Dosage	Medication Name	Dosage

Review of Systems:

Constitutional	☐ Fever	☐ Chills	☐ Fatigue	☐ Unexpected Weight Loss	☐ Loss of appetite
Integumentary	☐ Acne	☐ Rash	☐ Moles	☐ Itching	☐ Other
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Foreign Body Sensation	☐ Frequent Watering	☐ Sensitive to light
HENT	☐ Hearing Loss	☐ Sinus Congestion	☐ Sore Throat	☐ Runny Nose	☐ Dental Problems
Respiratory	☐ Cough	☐ Shortness of Breath	☐ Wheezing	☐ Coughing Blood	
Cardiovascular	☐ Chest Pain	☐ Irregular Heartbeat	☐ Palpitations		☐ Other
Gastrointestinal	☐ Nausea	☐ Vomiting	☐ Diarrhea/Constipation	☐ Acid Reflux	☐ Bloody Stools
Genitourinary	☐ Incontinence		☐ Frequent Urgent Urination	☐ Urinary Pain	☐ Bloody Urine
Endocrine	☐ Hair Loss	☐ Hot Flashes	☐ Cold/Heat Intolerance	☐ Increase Thirst	☐ Excessive BodyHair
Heme-Lymph	☐ Easy Bruising	☐ Clotting/ Bleeding Disorder	☐ Enlarged Lymph Nodes		☐ Other
Musculoskeletal	☐ Muscle Pain	☐ Joint Pain	☐ Joint Swelling	☐ Abnormal Spine Curvature	
Neurologic/Psychiatric	☐ Numbness/ Tingling		☐ Dizzy Spells	☐ Memory Loss	☐ Depression/ Anxiety

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Acknowledgement of Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Forsyth Eye Health and Surgery of all charges for services provided. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be made payable to me, to Forsyth Eye Health and Surgery for services rendered.

Acknowledgment of Cancellation Policy:

We ask that you provide at least 24 hours of notice if you are unable to keep your scheduled appointment. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your appointment. You may be subject to a fee for missed appointments. Multiple repeat occurrences may result in dismissal from our practice.

Acknowledgement of Pharmacologic Dilation:

We recommend a Dilated Examination as a baseline for new patients, for most diabetics and glaucoma patients, for certain other symptoms, and for established patients at certain reasonable intervals. This testing involves eyedrops that temporarily enlarges your pupils. Side effects include sensitivity to light and blurred near vision, expected to last approximately 4-24 hours in most patients.

☐ **YES,** I understand the side effects of pupil dilation and agree to this procedure on my first exam and any subsequent exam deemed medically necessary.

☐ **NO,** I prefer not to have my pupils dilated, even if it is recommended by my eye doctor. I understand that I could have diseases which remain undetected if I refuse a dilated examination.

Acknowledgment of Notice of Privacy Practices:

I voluntarily consent to healthcare treatment from Dr. Ringeman and staff at Forsyth Eye Health and Surgery. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me as the result of treatments and examinations by Dr. Ringeman. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I authorize Forsyth Eye Health and Surgery to release information acquired in the course of my examination and treatment to my insurance carriers. I have been made aware of Forsyth Eye Health and Surgery's Notice of Privacy Practice (available at the front desk). I have had the opportunity to ask questions and my questions have been answered

By signing below, you agree that you have read and understand the information above that has been provided to you.

_____	_____	_____
Patient Name (Print)	Date of Birth	Date of Signature
_____	_____	
Signature of Patient or Personal Representative	Relationship to Patient if signing for patient	

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