DATE:_____
TIME:_____
LOCATION:_____

Raymond A. Bannan, M.D.

300 Wharton Circle, Ste. 120
Triadelphia, WV 26059
(304) 909-0080
Fax (304) 909-0533

3372 Belmont Street
Bellaire, OH 43906
(740) 676-1121
Fax (740) 676-4467

Dear New Patient,

WELCOME TO THE OFFICE OF RAYMOND A. BANNAN, M.D.

The information noted above confirms the date, time and office location for your next appointment. Please complete the enclosed forms, and mail back to our office before your appointment.

Certain insurances require a referral to see us. It is imperative that you know your insurance. If a referral is required, you will need to contact your primary physician to obtain a referral. Without this referral, we will be unable to see you.

Co-Pays will also need to be paid on the day of your visit or you will not be seen. If you are unsure of your requirements regarding your insurance, please call your insurance carrier.

If you do not have insurance, please call the office for prices. If additional testing is necessary, this price may change. You should be prepared to pay this on the day of your visit.

We will be using dilating drops as part of your exam to check the back of your eyes. These drops may blur your vision, so it is advisable to have someone drive you to your appointment. Please bring sunglasses if you have them. Your visit with us may take at least two hours.

We will ask that each patient enters the office alone unless there is a compelling reason for you to be accompanied by a family member.

On the day of your appointment, please bring:

ALL INSURANCE CARDS WITH A LIST OF MEDICATIONS AND LIST OF SURGERIES
ALL YOUR MEDICATIONS IN THEIR ORIGINAL CONTAINERS OR MEDICINES AND THEIR DOSAGES
YOUR MOST CURRENT PAIR OF GLASSES

PLEASE REMEMBER TO USE OVER THE COUNTER, PRESERVATIVE-FREE SYSTANE® OR REFRESH® DROPS TWO TIMES DAILY FOR TWO (2) WEEKS IN BOTH EYES PRIOR TO YOUR APPOINTMENT

IF YOU ARE A CONTACT LENS WEARER, PLEASE LEAVE CONTACTS OUT OF YOUR EYES FOR TWO (2) WEEKS PRIOR TO YOUR APPOINTMENT.

Please feel free to contact us with any questions!

Sincerely,

Office Manager

FOR MORE INFORMATION ON CATARACT SURGERY AND OUR OTHER SERVICES, VISIT OUR WEBSITE AT: BANNANEYE.COM

PATIENT NAME

Last_____ First_____ Middle Initial____ Age_____

Date of Birth_____ Sex: ☐ M ☐ F Social Security Number_____

Address: _____

City _____ State_____ Zip Code_____

Phone Number_____ Cell Phone_____

Patient's Weight_____ Patient's Height_____

Employer_____

Address_____ Work Phone_____

Marital Status: ☐ M ☐ W ☐ D ☐ S Spouse_____

Spouse's Social Security Number _____ Date of Birth_____

Name of closet relative/friend to contact in case of an emergency (someone not residing with you):

Name_____ Phone_____

Relationship_____

Family Physician_____ Phone_____

Referring Physician_____ Phone_____

It is customary to pay for professional services at the time they are rendered if you have no insurance. Assistance will be provided to you in submitting appropriate insurance forms to your insurance carrier, if applicable. All fees are the responsibility of the (please circle) Patient / Parent / Guardian, unless Dr. Bannan is subject to specific contract arrangement with your insurance carrier.

- I hereby authorize Raymond A. Bannan, M.D. to release medical information relating to any insurance claim. ☐YES ☐NO
- I hereby authorize payment directly to Raymond A. Bannan, M.D. of the insurance benefits otherwise payable to me, ☐YES ☐NO
- I understand that any charge(s) not covered by my insurance carrier becomes my direct responsibility. ☐YES ☐NO

I hereby give permission to Dr. Raymond A. Bannan to take necessary clinical photographs for the following reasons:

- Clinical records only, which remain the property of the physician. ☐YES ☐NO
- For submission to my insurance carrier to determine availability of insurance. ☐YES ☐NO

NOTE: Failure to approve this section may result in your insurance denying benefits for the professional services provided to you and your responsibility to pay.

Signed (Patient / Parent / Guardian)_____ Date_____

Name:_____

PAST MEDICAL HISTORY

Do you currently have any problems in the following areas? If YES, please check the appropriate boxes that apply and you may provide an explanation of the problem. Please explain if the conditions are (C) controlled or (UC) uncontrolled.

Heart / Blood Vessels

Blood pressure □ YES □ NO □ C □ UC Explanation:_____
Angina □ YES □ NO □ C □ UC Explanation:_____
Heart Attack □ YES □ NO □ C □ UC Explanation:_____
Poor Circulation □ YES □ NO □ C □ UC Explanation:_____

Lungs / Breathing

Asthma □ YES □ NO □ C □ UC Explanation:_____
Emphysema □ YES □ NO □ C □ UC Explanation:_____

Stomach / Intestines

Ulcers □ YES □ NO □ C □ UC Explanation:_____
Tumors □ YES □ NO □ C □ UC Explanation:_____
Hernia □ YES □ NO □ C □ UC Explanation:_____
Other □ YES □ NO □ C □ UC Explanation:_____

Genitals / Kidneys / Bladder

Prostate □ YES □ NO □ C □ UC Explanation:_____
Other □ YES □ NO □ C □ UC Explanation:_____

Bone & Muscle

Muscle Pain □ YES □ NO □ C □ UC Explanation:_____
Joint Pain □ YES □ NO □ C □ UC Explanation:_____
Bone Disorders □ YES □ NO □ C □ UC Explanation:_____
Other □ YES □ NO □ C □ UC Explanation:_____

Skin/ Breast

Rashes □ YES □ NO □ C □ UC Explanation:_____
Cancer □ YES □ NO □ C □ UC Explanation:_____

Nerves – Brain

Seizure □ YES □ NO □ C □ UC Explanation:_____
Stroke □ YES □ NO □ C □ UC Explanation:_____
Headache □ YES □ NO □ C □ UC Explanation:_____
Depression □ YES □ NO □ C □ UC Explanation:_____
Nervousness □ YES □ NO □ C □ UC Explanation:_____
Anxiety □ YES □ NO □ C □ UC Explanation:_____

Gland Disorders

Diabetes □ YES □ NO □ C □ UC Explanation:_____
Thyroid Problems □ YES □ NO □ C □ UC Explanation:_____
Last blood sugar: _____ Range of sugar levels: _____

Blood Disorders

Anemia □ YES □ NO □ C □ UC Explanation:_____
Swollen Glands □ YES □ NO □ C □ UC Explanation:_____
Blood Clots □ YES □ NO □ C □ UC Explanation:_____
Bleeding Problems □ YES □ NO □ C □ UC Explanation:_____
Cholesterol □ YES □ NO □ C □ UC Explanation:_____
Last cholesterol reading: _____

Allergy

Head allergy sump. □ YES □ NO □ C □ UC Explanation:_____
Sinusitis □ YES □ NO □ C □ UC Explanation:_____
Dry throat/mouth □ YES □ NO □ C □ UC Explanation:_____
Other □ YES □ NO □ C □ UC Explanation:_____

Please describe any illness or injuries past or present not mentioned:_____
Are you allergic to any medications? □ YES □ NO If so, what?_____

Name:_____

FAMILY MEDICAL HISTORY

Do any immediate family members (grandparents, mother, father, brothers, sisters, aunts, or uncles) have any of the following? Please check the appropriate boxes that apply. Do not include yourself.

			RELATIONSHIP TO PATIENT
Lazy Eye	□ YES	□ NO	_____
Blindness	□ YES	□ NO	_____
Crossed Eye	□ YES	□ NO	_____
Cataract	□ YES	□ NO	_____
Glaucoma	□ YES	□ NO	_____
Macular Degeneration	□ YES	□ NO	_____
Retinal Detachment	□ YES	□ NO	_____
Arthritis	□ YES	□ NO	_____
Cancer	□ YES	□ NO	_____
Diabetes	□ YES	□ NO	_____
Heart attacks	□ YES	□ NO	_____
High blood pressure	□ YES	□ NO	_____
Kidney Disease	□ YES	□ NO	_____
Lupus	□ YES	□ NO	_____
Stroke	□ YES	□ NO	_____
Thyroid disease	□ YES	□ NO	_____
Tuberculosis	□ YES	□ NO	_____
Other	□ YES	□ NO	_____

Current occupation: _____

Do you drive? □ YES □ NO

Do you have visual difficulty when driving □ YES □ NO

Do you have a problem with night vision? □ YES □ NO

Have you ever tried to wear contacts? □ YES □ NO

Do you currently wear glasses? □ YES □ NO

If yes, how long have you had the current pair? _____

Name of Optometrist: _____

Do you drink alcohol? □ YES □ NO If yes, how many glasses per day? _____

Do you smoke? □ YES □ NO If yes, how many packs per day? _____

Have you ever had a blood transfusion? □ YES □ NO

Reason for your visit today:_____

_____

Reviewed with patient: _____ Date:_____

Thank you for completing this form!

Lifestyle Questionnaire

Raymond A. Bannan, M.D.

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Name:_____

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependency on glasses. Each option has potential advantages and disadvantages, depending on your lifestyle and the activities you enjoy. Please help us to better understand what is important to you in order to determine which option is best suited for your lifestyle and eye health.

What is (or was) your occupation?_____ Are you retired? □ Yes □ No

Please circle the following activities listed below that you do on a regular basis:

Read Newspapers/Books	Drive-Daytime	Drive-Nighttime	Play a Musical Instrument
Use a Cell Phone	Read Medicine Bottles	Shop	Dine in Restaurants
Watch Movies in Theater	Needlepoint/Sew	Play Tennis	Bicycle
Photography	Crossword Puzzles	Hunt or Fish	Play Cards/Board Games
Participate in Water Sports	Paint/Draw	Cook	Use the Computer
Watch Spectator Sports	Visit/Care for Grandchildren	Paperwork/Writing	Golf

Others:_____

Are you having difficulty with any of the activities listed above as a result of your vision?_____

_____

How many combined hours per day do you spend on a computer, tablet, and/or smartphone?_____

Please share anything else you think might be important about your lifestyle or daily activities:_____

_____

_____

Are there times in your day that you wish you didn't have to wear glasses? □ Yes □ No

If yes, explain when: _____

Please place an "X" on each continuum where it best describes how you feel about the following?

Correction of near vision:
(e.g., reading, use of phone)
I want to wear glasses — I don't want to wear glasses

Correction of intermediate vision:
(e.g., using a tablet/computer)
I want to wear glasses — I don't want to wear glasses

Correction of distance vision:
(e.g., driving, watching television)
I want to wear glasses — I don't want to wear glasses

Patient Signature:_____ Date:_____