SUBURBAN EYE CARE, P.C.

Name_____ Date_____

What is your main reason for your visit today? _____

Does your vision limit any of your activities? _____

Date of your last eye examination_____

Have you ever worn glasses? ❑Yes ❑No P Do you wear glasses now? ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports

Do you wear contact lenses at this time?	qYes	qNo
Have you had problems wearing contacts?	qYes	qNo
Have you been told you cannot wear them?	qYes	qNo
Are you interested in trying contacts?	qYes	qNo

Have you ever had vision therapy? ❑ Yes ❑ No

CURRENT MEDICATIONS:

_____

_____

DRUG ALLERGIES:

_____

_____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies	❑Self	❑ Family	Lazy eye	❑ Self	❑ Family
Respiratory Disease	❑Self	❑ Family	Turned eye	❑ Self	❑ Family
Cancer	❑Self	❑ Family	Color "blind"	❑ Self	❑ Family
Diabetes	❑Self	❑ Family	Light sensitive	❑ Self	❑ Family
Drug sensitive	❑Self	❑ Family	Dry eyes	❑ Self	❑ Family
Elevated Cholesterol	❑Self	❑ Family	Floaters/spots	❑ Self	❑ Family
Heart problem	❑Self	❑ Family	Flashing lights	❑ Self	❑ Family
High Blood Pressure	❑Self	❑ Family	Retinal Detachment	❑ Self	❑ Family
Thyroid	❑ Self	❑ Family	Blindness	❑ Self	❑ Family
Migraines or Headaches	❑Self	❑ Family	Cataracts	❑ Self	❑ Family
			Glaucoma	❑ Self	❑ Family
			Macular Degeneration	❑ Self	❑ Family

OCCUPATION: What kind of work do you do? _____

How many hours a day are you on the computer or other device? _____

Do you experience any of the following discomforts at work or at home?

q Headaches? q Letters blur as you read? q Occasionally see double?

q Eyestrain? q Eyes red or watery? q Pulling sensation near eyes?

q Get sleepy? q Lose your place often? q Do you avoid certain tasks?

q Does it take more and more effort to see clearly as the day wears on?

q Do you avoid reading after work, but read on weekends? How long can you read? _____

FOR FUN! What activities do you participate in?

_____

_

Do you wear any special or protective eyewear for your sport? q Yes q No

Does your vision, or do your lenses, interfere with any activity? q Yes q No

What are you doing to protect your eyes from the sun? _____

NEW PATIENTS: *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend or relative*_____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

❑ Dr. or other professional ❑ Online ❑ Article in publication ❑ Insurance ❑ Location

SUBURBAN EYE CARE, P.C.

Name_____ **Date of Birth**_____

Address_____

City_____ **State** _____ **ZIP**_____

Marital Status Single Married Divorced Widowed Domestic Partnership Other

Home Phone (_____) _____ **Cell Phone (_____)** _____

Email _____

Work Phone (_____) _____**Social Security #** ___ ___ ___ / ___ ___ / ___ ___ ___ ___

Race_____ **Are you Hispanic?** Yes No

Mother's Maiden name_____ **Birth State** _____

Person Responsible for account _____

FINANCIAL AUTHORIZATION:

I authorize and request my insurance company to pay directly to Suburban Eye Care, P.C.

I understand that my insurance carrier may pay less than the billed services and materials. I agree to be responsible for the payment of all services and materials rendered on my behalf or my dependents. Any portion not paid by the insurance company will be the patient's responsibility. A 1 ½% finance charge will be applied to any amount over 30 days.

_____ _____

Patient/ Guardian Signature **Date**

HIPAA PRIVACY POLICY:

I have received or was offered and declined a notice of Suburban Eye Care, P.C. privacy laws HIPAA.

_____ _____

Patient/ Guardian Signature **Date**

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Suburban Eye Care, P.C. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient/Guardian Signature **Date**