

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

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?

Yes

No

Have you had problems wearing contacts?

Yes

No

Have you been told you cannot wear them?

Yes

No

Are you interested in trying contacts?

Yes

No

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?

Headaches?

Letters blur as you read?

Occasionally see double?

Eyestrain?

Eyes red or watery?

Pulling sensation near eyes?

Get sleepy?

Lose your place often?

Do you avoid certain tasks?

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

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?

Yes  No

Does your vision, or do your lenses, interfere with any activity?

Yes  No

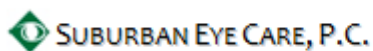
What are you doing to protect your eyes from the sun? \_\_\_\_\_

**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



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**