

Name _____ Email _____

Any changes to your vision or medical insurance? Y N

What is your main reason for your visit today? _____

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 your worn Contact lenses in the past? Yes No

How interested are you in contact lenses? (not interested) 1 2 3 4 5 6 7 8 9 10 (very interested)

Have you ever had vision therapy? Yes No

Have you ever had eye surgery? Yes Procedure type, eye and date _____ No

Do you use Tobacco? Yes No Do you drink alcohol? Yes Amount per week _____ No

Your current height _____ and weight _____.

CURRENT MEDICATIONS:

DRUG ALLERGIES:

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

Allergies	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Lazy eye	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Cancer	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Color "blind"	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Light sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Drug sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Dry eyes	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Elevated			Floaters/spots	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Cholesterol	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Flashing lights	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Heart problem	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Retinal		
High Blood			Detachment	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Pressure	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Blindness	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Cataracts	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Migraines or			Glaucoma	<input type="checkbox"/> Self	<input type="checkbox"/> Family
Headaches	<input type="checkbox"/> Self	<input type="checkbox"/> Family	Macular		
			Degeneration	<input type="checkbox"/> Self	<input type="checkbox"/> 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?

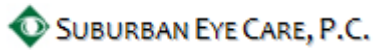
<input type="checkbox"/> Headaches	<input type="checkbox"/> Letters blur as you read	<input type="checkbox"/> See double
<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Eyes red or watery	<input type="checkbox"/> Pulling sensation near eyes
<input type="checkbox"/> Get sleepy	<input type="checkbox"/> Lose your place often	<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Does it take more and more effort to see clearly as the day wears on		
<input type="checkbox"/> 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? _____



Name _____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____

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

Email _____ Social Security # _____ / _____ / _____

Marital Status: Single Married Divorced Widowed Domestic Partnership Birth State _____

Race _____ Are you Hispanic? Y N Mothers Maiden Name _____

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 1/2% finance charge will be applied to any amount over 30 days.

X _____

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.

X _____

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.

X _____

Patient/Guardian Signature

Date

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:

- Saw the office Yellow Pages Article in publication Insurance Ad or Flyer