PERSONAL AND MEDICAL BACKGROUND INFORMATION

Patient Name _____ Date_____ Time _____

E-Mail _____ Height_____ Weight_____

1. The main reason/s for today's visit is / are: _____

   _____

2. When was your last: Eye Examination? _____ General Physical? _____

3. **MEDICAL HISTORY**: Please list ALL …
   Medical problems (Diabetes, High Blood Pressure, Kidney Disease, Cancer, etc.)
   Medications that you are taking, and what you are taking them for:

   _____

   _____

4. Have you had any serious **EYE or HEAD** injuries, illnesses, or surgeries?

   _____

5. If you have headaches, please describe what part of the head, and how often, and when they began.

   _____

6. Is there anyone in your family that has had severe eye problems or health problems ?

   _____

7. Medical Insurance: _____ Has this changed? **Yes** **No**
8. Vision Plan: _____ Has this changed? **Yes** **No**

9. **OPTOMAP RETINAL EXAM:**
   The Optomap Retinal Examination is a picture of the retina (back part of the eye). No eyedrops.
   The advantages to you are:
   1. Fast (less than 1 second per eye) and there is No blurred vision afterwards.
   2. You are able to see the back part of your own eye, and have the doctor explain the findings.
   3. It is now part of your record, and allows us to compare the retina from year to year.

   This new technology is a part of our standard of care and the fee for this test is **$39.00**.
   This test is not covered by any medical insurance. I choose to have this test……. **Yes** **No**

10. Name of: Husband_____ Wife_____
    If patient is a child: Father_____ Mother_____
    Please list your children's names and their ages: _____

    _____

11. **The Comprehensive Examination** addresses eye health and eyeglass prescriptions.

12. **Contact Lens Examination:** There are 3 levels; standard, complex, and custom.
    The fee for this service is separate from the comprehensive examination.
    _____
    initials

13. **Contact Lens Assessment** for individuals who are wearing Contact Lenses:
    This service (1) assesses the fit, positioning, power, corneal health, etc. with your contact lenses on, and then (2) assess your cornea and prescription (refraction) after removing your contact lenses. This additional testing is separate from a Comprehensive Examination. The fee for this assessment starts at **$25.00**.
    _____
    initials

PLEASE TURN OVER – Continued on other side

	Yes	No
1 Are you interested in getting eyeglasses today?		
2 Are you interested in getting contact lenses?		
3 Are you interested in contact lenses for occasional wear, such as sports or social events?		
4 Is your child having school-related problems or difficulty reading?		
5 Are you having vision problems after LASIK or PRK?		
6 Are you having vision problems after Brain injury? Crash, fall, etc.		
7 Are you interested in learning about a Non-Surgical method to correct your vision?		

8 Do you wear: [] Eyeglasses? [] Contact Lenses?

10 Do you see clearly **at distance**, for example, driving or watching TV?		
Only if I wear my [] Eyeglasses? [] Contact Lenses?		
11 Do you see clearly **at near**, for example reading, sewing, computer?		
Only if I wear my [] Eyeglasses? [] Contact Lenses?		

12 Do your eyes []burn []Itch []feel dry []Have discharge [] tear or water excessively

13 Do your eyes feel []painful []achy []irritated as though there is something in your eyes

14 Do you ever see []double []floaters []flashes of light []sudden blurred or reduced vision

15 Are you bothered by []glare []smoke []allergies []bright sunlight []artificial lights []sinus problems

16 Occupation - what type of work do you do? _____

17 At work, do you… []sit []stand [] work above eye level []use computer extensively

18 Hobbies - what types of things do you like to do?

[] Near work such as reading, crosswords, cards, crafts [] other_____

19 What sports are you involved in?

[]basketball []golf []swim []tennis []racquetball [] other_____

Family Eye Care
Dr. S. Moshe Roth, OD, FCOVD

Board Certified in Developmental Vision and Therapy
Fellow of College of Optometrists in Vision Development

Developmental and Behavioral Optometry
Treatment of Eye Disease
Orthokeratology
Vision Therapy

Name of Patient: _____

Health Insurance Claim Number (if applicable):_____

Social Security Number:_____

Insurance Payment and Coverage

- I request that payment of authorized Insurance, benefits be made either to me or on my behalf to Dr. S. Moshe Roth, OD for services furnished me by that physician.
- I authorize any holder of medical information about me to be released to the Insurance Administrator and its agents and authorize this office to obtain any information needed to determine benefits for related services.
- I understand that any insurance deductibles and co-payments are my responsibility. If, for any reason, my insurance company is unwilling to pay for services, or pays less that anticipated, I accept responsibility for those charges.
- I understand that some services offered at this office may not be covered under my insurance, such as Contact Lens Evaluation, Sensory Motor Evaluation, Low Vision Evaluation, etc.

Information Release

I authorize Dr. Roth to release information to, and discuss any medical history with other doctors, therapists, educators and insurance company representatives.

HIPPA Notice of Privacy Practice

I acknowledge that I received a copy of this office's Notice of Privacy Practice.

Financial Responsibility

- I understand that all payments are to be made at the time of services rendered.
- I understand that a fee of $5.00 per month will be added to any account balances, and that these service charges become my responsibility as well.
- I understand that a fee of $50.00 will be charged to my account if it is turned over to a Collection Agency.

Please indicate the method of payment of professional services:

[ ] Cash
[ ] Check
[ ] Credit Card (Master Card, Visa, Discover)
[ ] Care Credit, our monthly payment plan

Patient's Signature: _____ Date: _____

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