

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**
 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 | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Lazy eye | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Respiratory Disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Turned 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 Cholesterol | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Floaters/spots | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart problem | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Flashing lights | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High Blood Pressure | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Retinal Detachment | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Thyroid | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Blindness | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Migraines or Headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Cataracts | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| | | | Glaucoma | <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"/> Occasionally 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"/> Do you avoid certain tasks? |
| <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

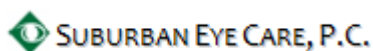
What are you doing to protect your eyes from the sun? _____

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