SUBURBAN EYE CARE, P.C.

Name ____ **Date of Birth** ____________________________

Any changes to your vision plan or medical insurance? Y N Email ____________________________

Emergency Contact: _____________________________________ **Phone #:**________________________

Pharmacy:____________________________Crossroads:__________________________City:_____________

What is your main reason for your visit today? ____

When was your last eye exam, ***if not with us***? _________________________________

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? θYes θNo Have you worn contact lenses in the past? θYes θNo

How interested are you in contact lenses? (not interested) 1 2 3 4 5 (very interested)

Have you ever had vision therapy? θ Yes θ No

Do you use tobacco? θYes θNo Do you drink alcohol? θYes θNo Drug use? θYes θNo

Your current height _________ and current weight __________.

Suburban Eyecare can now electronically view medication history for our patients.

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient has asked to not be disclosed due to privacy concerns, we will also verify medication history independently with the patient. **Patient's consent to view their medication history: θYes θNo**

CURRENT MEDICATIONS: **DRUG ALLERGIES:**

____ ____

____ ____

____

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

Condition	Self	Family
Cancer	❑Self	❑ Family
Cholesterol	❑Self	❑ Family
Stroke	❑Self	❑ Family
High Blood Pressure	❑Self	❑ Family
Diabetes	θSelf	θ Family
Thyroid	❑ Self	❑ Family
Multiple Sclerosis	θ Self	
Migraines or Headaches	❑Self	
Allergies	θSelf	
Light sensitive	θ Self	

Condition	Self	Family
Dry eyes	θ Self	θ Family
Lazy eye	❑ Self	❑ Family
Color "blind"	❑ Self	❑ Family
Floaters/spots	❑ Self	❑ Family
Flashing lights	❑ Self	❑ Family
Retinal Detachment	❑ Self	❑ Family
Blindness	❑ Self	❑ Family
Cataracts	❑ Self	❑ Family
Glaucoma	❑ Self	❑ Family
Macular Degeneration	❑ Self	❑ Family

Other: _______________________________

Have you ever had eye surgery? θ Yes θ No Type and eye_________________________________

OCCUPATION: What kind of work do you do? ____

How many hours a day are you on a computer or another device? ____________________

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

θ Headaches θ Letters blur as you read θ See double

θ Eyestrain θ Eyes red or watery θ Pulling sensation near eyes

θ Get sleepy θ Lose your place often θ Blurred vision

θ Does it take more effort to see clearly as the day wears on θ Do you avoid reading after work

FOR FUN! What activities do you participate in? ____

Do you wear any protective eyewear for your sport? θ Yes θ No

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

SUBURBAN EYE CARE, P.C.

Name_______________________________ **Date of Birth**____________________

Address____

City______________________________ **State** ___________ **ZIP**______________________

Home Phone (_______) __________________ **Cell Phone (______)** ________________________

Social Security # ___ ___ ___ / ___ ___ / ___ ___ ___ ___ **Birth State**_________

Marital Status: Single Married Divorced Domestic Partnership Widowed

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 ½% finance charge will be applied to any amount over 30 days.

X ___________________________________ ____________________

Patient/ Guardian Signature **Date**

HIPAA PRIVACY POLICY:

I hereby acknowledge that I was presented a notice of Suburban Eye Care, P.C. privacy HIPPA statement.

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 ❑ Internet Search ❑ Ad in publication ❑ Insurance ❑ Doctor Talk/ Workshop