METROPOLITAN VISION

downtown

60 St. James Place, New York, NY 10038 | Tel: (212) 227-1268 | Fax: (888) 534-1721
info@metropolitanvisionnyc.com | www.metropolitanvisionnyc.com | Follow us @mvdowntown

Circle one Mr. Ms. Mrs. Dr.	**Last Name**	**First**	**Middle**

Street Address **Apt #**

City **State** **Zip**

Home #	
Work #	
Cell #	
Email	

(Email info for reminders of glasses and contact lens only)

SSN				
DOB		**Age**		**M I F**
If Minor, Parent Name				

Employer	
Occupation	
Referred by	

May we use your name in thanking this person? Y__ N__

Primary Care Doctor	
Phone #	

Vision Plan	
ID #	

Medical Ins	
ID #	
Primary Insured Name & DOB	

General Eye/Vision Questions

Do you wear glasses?			Y	N
Type:	Distance	Reading	Bifocal	Progressive

Do you wear contact lenses?	Y	N

Brand?	
Solution?	
Age of current lenses	

Please briefly describe the reason for your visit. Any problems with your eyes, glasses or contact lenses?

*Please also complete the patient history questionnaire

Patient Consent / Authorization of Payment / HIPPA Acknowledgment

I hereby authorize payment of any insurance benefits on my behalf directly to Metropolitan Vision Downtown for any service furnished by their Doctors and/or Associates. I also authorize any holder of medical information about me to release any information needed to determine benefits or benefits payable for related services to the health care financing administration and its agents or third party payers. Additionally, it is my responsibility to understand and adhere to the provisions and regulations of my insurance provider. I further understand that I will be responsible for fees for services outside the coverage of my insurance program.

I have been given the opportunity to read a copy of Metropolitan Vision Downtown's Notice of Privacy Practices.

Signature (parent or guardian if minor) Date

Please sign and date at the time of your appointment

METROPOLITAN VISION DOWNTOWN - PATIENT HISTORY QUESTIONNAIRE

Name:	DOB:	SSN:
Today's Date:	Last Eye Exam:	Were you dilated? Y | N

OCULAR / EYE HISTORY

Do you have any of the following symptoms?	Y	N
Blurred distance vision		
Blurred near vision		
Sudden loss of vision		
Eye strain while reading or at the computer		
Burning | Itch | Discharge		
Grittiness or dryness		
Watery Eyes		
Double Vision		
Eye Pain		
Glare | Light Sensitivity | Halos		
Floaters or spots in vision		
Flashes of light		
Night vision problems		
Other:		

Have you been told you have the following?	Y	N
Glaucoma or high eye pressure		
Cataracts		
Macula Degeneration		
Keratoconus		
Retinal holes or tears or detachments		
Other:		

Please List your **ALLERGIES** ☐ none

Please List your **MEDICATIONS** ☐ none
(please include eye and medical)

MEDICAL HISTORY

Do you have any of the following?	Y	N
Heart Disease		
Hypertension (High blood pressure)		
Diabetes		
High Cholesterol		
Asthma		
Migraines | Headaches		
Arthritis		
Multiple Sclerosis (MS)		
HIV		
Cancer		
Other | Surgeries:		

Do you have any problems with these systems?

	Y	N		Y	N
Allergic/Immune			Genitourinary		
Blood / Lymph			Mental		
Cardiovascular			Musculoskeletal		
Ear/Nose/Throat			Nervous		
Endocrine (glands)			Respiratory		
Gastrointestinal			Skin		

Please Explain:

FAMILY HISTORY

Do any family members have the following?

	Y	N	Relation
Glaucoma			
Macula Degeneration			
Blindness			
Eye turn / lazy eye			
Diabetes			
Hypertension			

Doctors use only - do not write below this line

Today's Date:	Date: ☐ No changes ☐ Changes as noted	Date: ☐ No changes ☐ Changes as noted
Dr. Initials:	Dr. Initials:	Dr. Initials: