Hartsdale Family Eyecare

First _____ Middle _____ Last _____

DOB_____ Age _____ ❑Male ❑Female SSN _____

Street _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ Day/Work Phone _____

Cell Phone _____ Email _____

Employer or School _____ Occupation or Grade _____

Pharmacy Info:

Business _____

Phone _____

Location _____

How were you referred to us?

❑ Insurance List ❑ Yellow Pages ❑ Facebook ❑ Yelp
❑ Magazine or Ad ❑ Google ❑ From Neighborhood

❑ Another doctor? _____

❑ Another patient? _____

Reason For Visit:

❑ Annual ❑ Other _____

Please list any symptoms you are experiencing:

_____

_____

***Medical insurance will ONLY provide coverage if there is a medical reason such as blurred or loss of vision, glaucoma, cataracts, etc

Interested in:

❑ Glasses ❑ Sunglasses ❑ Contact lenses
❑ Laser Vision Correction ❑ OrthoKeratology

Insurance Info:

Vision Insurance_____

Primary Medical _____

Secondary Medical _____

Policy Holder:

❑ I am the Policy Holder
OR

Full Name _____

SSN _____

DOB _____ Relation _____

***Please be advised that we are considered a specialist. If a REFERRAL or PRIOR AUTHORIZATION is required from your Primary Care Physician and has not been obtained beforehand, you will be responsible for any outstanding balance

***Acknowledgement: Initials _____ Date _____

Vision Concerns:

Are you experiencing *ANY* of the following:

❑ Blurred Vision	❑ Sensitivity to Light	❑ Night Glare
❑ Eyestrain	❑ Headache	❑ Double Vision
❑ Eye Pain	❑ Poor Night Vision	❑ Loss of Vision
❑ Dry Eyes	❑ Flashes/Floaters	❑ Discharge