WELCOME TO VISION ASSOCIATES

Name _____ Date of Birth _____ Age _____ Occupation _____

Address _____ Apt/Floor _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ EMAIL ADDRESS _____

TODAY'S VISIT WILL BE PAID BY:

☐ CASH ☐ CHECK ☐ INSURANCE ☐ CREDIT CARD ☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ OTHER

Medical Insurance _____ ID # _____ Name of Insured _____ DOB: _____

Vision Plan _____ ID # _____ Name of Insured _____ DOB: _____

Do you need an eyeglass prescription today? _____ Do you need a contact lens evaluation today: _____

Is your general health good? **YES / NO**

PLEASE CHECK THE BOX IF YOU HAVE A HISTORY OF THE FOLLOWING

Ear/Nose/Throat Problems?		Cardiovascular Issues	
Respiratory Issues?		Musculoskeletal Problems?	
Genitourinary (Urinary/Genital)		Neurologic (Brain/Spine) Issues?	
Skin Problems?		Endocrine (Thyroid/Diabetes) Issues?	
Psychiatric Concerns or Problems?		Allergies/Immunologic Issues?	
Blood Disorders?		Do You Smoke?	
Eye Diseases/Problems?		Do You Consume Alcohol?	

Please explain all YES answers:

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

PLEASE READ AND SIGN THE FOLLOWING:

Examinations to prescribe lenses (Refraction) may not be covered by Medicare or most major medical health plans. Additional fees may apply. Most Vision plans do not cover medical eye care. Additional fees may apply. I request payment of authorized Medicare/insurance benefits be made on my behalf to Vision Associates of Sheepshead Bay, Inc. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents information needed to determine these benefits or the benefits payable for related services. I have also received the notice of privacy practices. I have read, understand, and agree to the terms of the privacy notice.

PATIENT SIGNATURE: _____ **DATE:** _____