

## Patient History

Name \_\_\_\_\_ Age \_\_\_\_\_ D.O.B \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Home phone # \_\_\_\_\_ Bus Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

TODAYS EXAMINATION WILL BE PAID BY: (CIRCLE ONE):

Cash   Check   Insurance   Credit Card   HMO   Medicare   Medicaid   Other

Medical Insurance and ID # \_\_\_\_\_

Member name: \_\_\_\_\_ Member Social: \_\_\_\_\_ Member D.O.B: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Vision Plan: \_\_\_\_\_

Do you need a prescription for eyeglasses? \_\_\_\_\_

Do you need a contact lens evaluation/reevaluation? \_\_\_\_\_

**Do you have a history of disease or problems with any of the following listed below:**

*Please circle "yes" or "no". Please give a brief description for any positive responses.*

<b>Feeling well:</b>	yes/no _____
<b>Ears, nose, throat:</b>	yes/no _____
<b>Respiratory:</b>	yes/no _____
<b>Genitourinary:</b>	yes/no _____
<b>Skin:</b>	yes/no _____
<b>Psychiatric:</b>	yes/no _____
<b>Blood disorders:</b>	yes/no _____
<b>Eye:</b>	yes/no _____
<b>Cardiovascular:</b>	yes/no _____
<b>Gastrointestinal:</b>	yes/no _____
<b>Musculo/Skeletal:</b>	yes/no _____
<b>Neurologic:</b>	yes/no _____
<b>Endocrine:</b>	yes/no _____
<b>Allergic/Immune:</b>	yes/no _____
<b>Medications:</b>	yes/no _____

\_\_\_\_\_

\_\_\_\_\_

Please list any pertinent past, family, occupational or social history. If not, write "none"

(a.) Occupational \_\_\_\_\_

(b.) Social (do you smoke? \_\_\_\_\_. Do you suffer from substance abuse \_\_\_\_\_)?

(c.) Family \_\_\_\_\_

(d.) Past \_\_\_\_\_

### PLEASE READ 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 the 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 Health Care Financing Administration and its agents any 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 \_\_\_\_\_