

Date _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Primary Care Physician _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____ Home Phone () _____ Cell Phone () _____

What is your reason for visit? _____ Last exam date _____

CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Floaters	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Sensitivity to Light
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Wear Contact Lenses
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seeing Flashes	Type of Lenses _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seeing Halos	Hours per Day _____

Check (✓) if your blood relatives had any of the following:

Disease	Relationship to you
Blindness	
Cataracts	
Diabetes	
Glaucoma	

ALLERGIES you have to medications or substances

MEDICATIONS List medications you are currently taking

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Name of Insured _____

Contract # _____ Group # _____ Subscriber I.D. # _____

AUTHORIZATIONS

I certify that I have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Dr. Nicolette Sacco-Brown all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

Family Eyecare Center _____ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary