Name Last Name F	120 A 200 A				
		Middle Initial			
Address					
City				•	
Sex M F Age Birthdate		Married Separated	☐ Widowed☐ Divorced	☐ Single☐ Partnered for _	Warrange .
Primary Care Physician	o	ccupation			440
Employer/School Address	E	mployer/Schoo	l Phone ()		
Whom may we thank for referring you?		Home Phone () Cell Phone ()			
What is your reason for visit?					
CONE	DITIONS Check(🗸) condi	tions you have	or have had in the	past.	
Blurred Vision Double Vision			Loss of Vision	☐ Sensitivity	to Light
☐ Cataracts ☐ Eye Infection	☐ Glaucoma] Retinal Disease	☐ Wear Con	
☐ Crossed Eyes ☐ Eye Injury	☐ Headaches		Seeing Flashes		ses
☐ Diabetes ☐ Eye Surgery	☐ Hypertension	ı [Seeing Halos	Hours per [)ay
Check (✓) if your blood relatives had Disease Re	any of the following: elationship to you	Δ1 1	FRGIES you have	e to medications or	cuhetange
Blindness	national to you	75	- you have	to medications of	Substances
Cataracts	·	MED	ICATIONS List me	dications you are c	urrently taking
Diabetes				dications you are o	unomy taking
Glaucoma					
Person Responsible for Account	me		First Name		Middle Initial
Relation to PatientBirthda		Soc. Sec.#			
Address (if different from patient's)		Phone ()			
City		StateZip			
Person Responsible Employed by			Occupation		
Business Address				one ()	
Insurance Company				3	
Contract #					
	AUTHOR	IZATIONS	3	2000	1000
I certify that I have insurance coverage with		M			and assign directly
Dr. Nicolette Sacco-Brown am financially responsible for all charges whether o	all insuran		y, otherwise payable to		red. I understand that
The above-named doctor may use my health care purpose of obtaining payment for services and detendent plan is completed or one year from the date services.	information and may disclose suc ermining insurance benefits or th	h information to	the above-named Insu	rance Company(ies) ar	d their agents for the hen my current treat-
Medicare/Medigap Authorization: I request that p	payment of authorized Medicare t			nefits, be made either to	me or on my behalf
	for any services				
Family Eyecare Center Name of Doctor or Clinic	for any services		-	v Madinass and ***	d Condens
Family Eyecare Center	ler of medical or other information	about me to rel	ease to the Centers fo	r Medicare and Medicai	d Services, my

Relationship to Beneficiary

Please print name of Beneficiary, Guardian or Personal Representative