# NEW PATIENT INFORMATION

**Today's Date: _____ Email address: _____**

**PERSONAL INFORMATION – (Please Print)**

**Patient Name: _____Age: _____**

**Address: _____ City _____ State _____ Zip _____**

**Home Phone: (_____)_____ Work Phone:(___)_____**

**Date of Birth: _____ S.S. #: _____**

**Sex: Male / Female**

**Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐**

**Employment Status Employed☐ Unemployed☐ Retired☐ Disabled ☐**

**Employer: _____ Occupation:_____**
**Work Phone: _____**

**Spouse's Name: _____Spouse's Date of Birth:_____**
**Employer: _____ Work Phone: _____**

**Primary Care/ Family Doctor: _____**

**Referred by:**
**☐ Friend/Relative _____ ☐Doctor: _____**

**☐Internet ☐Insurance ☐Website ☐Other: _____**

**Who to notify in an emergency (nearest relative or friend)?**

**Name: _____Relationship: _____**
**Phone: _____**

**Complete if under 18 years or a student**

**Name of Father: _____Social Security # _____**

**Phone: _____**

**Name of Mother: _____ Social Security # _____**

**Phone_____**

**INSURANCE INFORMATION (Please bring insurance cards and drivers license to the front desk)**

**Primary Insurance: _____ # _____**
**Co-pay Amount:_____**

**Name of:**

**Policyholder: _____Social Security # _____**

**Date of Birth: _____**

**Secondary Insurance: _____ # _____**

**Co-pay Amt: _____**

**Name of:**

**Policyholder: _____Social Security # _____**

**Date of Birth: _____**

**Patient Name: _____**

## FINANCIAL ASSIGNMENT AND AGREEMENTS

- **I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.**
- **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to (Rothchild Eye Institute) for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.**
- **I understand that I am financially responsible for all charges not covered by insurance.**
- **I give permission to (Rothchild Eye Institute) to access records regarding my medical conditions.**
- **I authorize (Rothchild Eye Institute) to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.**
- **I agree to the release of my medical information to my personal physician(s), or optometrist(s).**

- **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

  **1. _____ 2. _____**

  **3. _____ 4. _____**

**I acknowledge that a copy of (Rothchild Eye Institute) Notice of Privacy Practices has been provided to me for review and that a copy is available at my request.**

**Signature: _____ Date: _____**
**(Patient or legal guardian)**

**Witness: _____ Date: _____**
**(Practice Representative)**

Medical History Questionnaire

Name _____ Date_____

Date of Birth_____

Date of last eye exam_____ By Dr._____

Primary Care Doctor_____

List any medications you currently take (prescription and over the counter): _____

_____

_____

Do you have any allergies to any medications? ☐YES ☐NO
If yes, please list the medications:_____

List all major illnesses (glaucoma, diabetes, heart attack, etc.) or injuries (concussions, etc.):

_____

_

List any surgeries you have had (Ex: cataract, tonsillectomy): _____

_____

Do you currently have any problems in the following areas? If "YES" please provide information.

| | YES | NO | Explanation of problem. |
|---|---|---|---|
| EYES (Glaucoma, cataract, retinal disease, etc.) | | | |
| Loss of vision | | | |
| Blurred vision | | | |
| Fluctuating vision | | | |
| Distorted vision (halos) | | | |
| Loss of side vision | | | |
| Double vision | | | |
| Dryness | | | |
| Mucous discharge | | | |
| Redness | | | |
| Sandy or Gritty feeling | | | |
| Itching | | | |
| Burning | | | |
| Foreign body sensation | | | |
| Excess tearing/watering | | | |
| Glare/light sensitivity | | | |
| Eye pain or soreness | | | |
| Infection of eye or lid (blepharitis, stye) | | | |
| Tired eyes | | | |
| Crossed eyes, lazy eye | | | |
| Drooping eye lid | | | |
| General/Constitutional | | | |
| Fever | | | |
| Weight loss | | | |
| Other | | | |
| Ears, Nose, Throat (Sinus, ear infection, chronic cough, dry mouth, Etc.) | | | |
| Heart and Blood (Heart, vessels, etc.) | | | |

| | | | |
|---|---|---|---|
| Lung (Asthma, emphysema, etc.) | | | |
| Gastrointestinal (Stomach ulcers, intestinal disease) | | | |
| Genital, Kidney, Bladder | | | |
| Muscles, Bones, Joints (Arthritis, etc.) | | | |
| Skin (Acne, warts, skin cancer, etc.) | | | |
| Neurological (Stroke, multiple sclerosis, etc.) | | | |
| Psychiatric (Anxiety, depression, insomnia, ect.) | | | |
| Endocrine (Diabetes, thyroid, etc.) | | | |
| Blood/Lymph (cholesterolemia, anemia, etc.) | | | |
| Allergic/Immunologic (Hay fever, lupus, Sjogrens, AIDS) | | | |

Family History

Any family eye disease? If "YES" please list: M = mother F = Father S = Sibling GP = Grandparent☐

| Disease | YES | NO | Explanation of problem. |
|---|---|---|---|
| Blindness | | | |
| Cataract | | | |
| Glaucoma | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart disease or high blood pressure | | | |
| Kidney disease | | | |
| Lupus | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Other | | | |

Social History

Current occupation:

Marital status (married, divorced, single, widowed): _____

Do you drive? ☐YES ☐NO

Do you have visual difficulty when driving? ☐YES ☐NO

Do you drink alcohol? ☐YES ☐NO If yes, ☐occasional, ☐more than 4/day

Do you smoke? ☐YES ☐NO If yes, how much per day _____

Have you ever had a blood transfusion? ☐YES ☐NO

_____

Patients Signature/Or Person Authorized to sign for patient

# REFRACTIONS

**What is a Refraction?** Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trail lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

**When Does Insurance NOT pay for a Refraction?** Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMO's, and most private policies will not pay for refraction. Almost all insurance payors consider a refraction is merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

**Who Has Made This Distinction for Insurance Coverage?** It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered their policies, and not your individual physician. Therefore, if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

**What is Our Policy?** At Rothchild Eye Institute we are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, refraction will be performed when medically necessary (typically this includes all new patients, those presenting with decreased vision and on a yearly basis thereafter). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is **$70.00** and is collected at the time of your visit, in addition to any co-payments or deductible due for the medical portion of your examination. As a courtesy we will send in a claim to your insurance for the refraction and if by chance they do pay for it we will reimburse you.

I have read the above information and understand that the refraction is a **NON-COVERED** service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

_____ _____

Signature Date

# CONTACT LENS INFORMATION

**Are you currently a Contact Lens wearer? YES or NO**

**If yes, for how many years?_____**

**Which brand of Contact Lenses are you currently wearing?**
**_____**

**Did you bring your Contact Lens boxes in with you today? YES or NO**