Welcome to Our Office

Name_____ Date____/____/____ Birthday___/____/____ Age_____

Address_____ City_____ State_____ Zip_____

Phone (home)_____-_____-_____ (work)_____-_____-_____ (cell)_____-_____-_____

Email_____ SS#_____-_____-_____

Sex M F Marital Status Sing. Mar. Other Occupation_____Spouse's Name_____

If student what grade?_____ What School?_____ Parent's Name_____

Last Eye Exam_____yrs by _____ Last Eyeglasses_____yrs Last Physical Exam_____yrs by _____

Medical History

Do you take any medications or vitamins y n please list _____

_____

(USE BACK IF NEEDED)

Are you allergic to any medications? y n please list_____

Do you or a family member have (sugar) Diabetes? y n Do you have Arthritis? y n

Do you or a family member have High Blood Pressure? y n Do you have Thyroid Dysfunction? y n

Do you or a family member have Heart Troubles? y n Do you have any other medical conditions? y n

Have you or a family member had cancer? y n Do you currently smoke? y n

Eye Health History

Do you or a family member have Glaucoma? y n Do you or a family member have Cataracts? y n

Do you or a family member have Macular Degeneration? y n Have you ever had eye surgery? y n

Do you or a family member have a lazy eye or eye turn? y n Do you have problems with dry eye or tearing? y n

Do you wear or are you interested in contact lenses? y n Do you suffer from eye allergies? y n

What is the reason for today's visit?_____

Insurance/Release of Information

Do you have routine vision insurance? y n Do you have medical insurance? y n

Primary Insured Name_____ Primary Insured DOB___/___/___ check if different address []

The staff at Shore Family Eyecare will be happy to submit to your insurance for your visit. It is your responsibility to know if your insurance covers the type of office procedures performed and whether referrals are necessary.

I am responsible for all fees, referrals, co-pays, deductibles and non-covered procedures and devices provided. I authorize Shore Family Eyecare to submit to my insurance and assign the benefits to be directly paid to the doctors of Shore Family Eyecare when applicable.

I understand that Shore Family Eyecare is fully compliant with HIPAA regulations and privacy issues. I request my professional records/reports only to be released to Shore Family Eyecare when necessary and to release my records to other doctors/professionals who may provide care for me in the future.

(signature)_____Date____/_____/_____

How did you hear about Shore Family Eyecare? Dietrich Opticians NJ Commission for the Blind Pediatrician Newspaper Internet/Website School Nurse/OT Eye Doctor Family Friend Insurance

Thank you for your confidence