Welcome to Our Office

Patient Information

Mr. ☐ **Dr.** ☐
Mrs. ☐ **Ms.** ☐

Today's Date: ____________

Name: ____ **Date of Birth**:___________ **Age**: _____

Street Address: ____Social Security #: __________________

City:____State: ________Zip: ________________

Home #: _________________________Cell #: _____________________ Work #: __________________

Email Address: ____

(Used only to send information and confirming appointments)

Race: ______________ Ethnicity: __________________ Primary Language: __________________________
Employer: ______________________________________ ***Occupation***:______________________________
Parent/Spouse Name: ___________________________________ Phone #: __________________________
Address: ____

PATIENT HISTORY

Name of PCP (primary care provider): _____________________________ Phone #: ___________________
Address: ____
Last Eye Exam: ______________________ **Last General Physical Exam:**_________________________
List Medical Conditions for which you are being treated: ____
____
Current Medications (include vitamins, eye drops/ointments): ______________________________________
____
List all medications you are **ALLERGIC** to: ____
History of Surgery (including Lasik): ____
____
History of Trauma to Head or Eyes: ____
____
Do you Smoke? YES or NO If yes, how much? _______________________
Do you Drink? YES or NO If yes, how much? ________________________

***VISION PLAN (Circle one):** VSP/Nassau County/Davis/Eye Med/ Other: _____________________

Primary MEDICAL Insurance Information

Policy holder Name: ___________________________ SS#: ___________________ DOB:_______________
Insurance Co: ____________________________________ ID/Policy #: _____________________________
Relationship to patient: ___________________ Employer: _______________________________________

Secondary Insurance to File

Name: ____ SS#: __________________
DOB:_________________
Insurance Co: _________________ ID/Policy #: ________________ Relationship to patient: ____________

Health History

Do you Have?	Y	N	Family	Do You Have?	Y	N	Family	Do You Have?	Y	N	Family
Diabetes				High Cholesterol				Headaches			
Hypertension				Cancer				Neurological Problems			
Kidney Problems				Arthritis				Surgery			
Thyroid Problems				Heart Problems							

Eye Health History

Do you Have?	Y	N	Family	Do You Have?	Y	N	Family	Do you have?	Y	N	Family
Macular Degeneration				Glaucoma Suspect				Lasik			
Cataracts				"Freckle" in the Eye				Laser			
Glaucoma				History of Blindness				Injections			

Vision Correction History (*please check any that apply*)

Amblyopia (Lazy Eye) ☐
Blurred vision at a distance ☐
Blurred vision at near ☐
Burning ☐
Double vision ☐
Drooping eyelid ☐
Dryness ☐
Eye pain/soreness ☐
Floaters or spots ☐

Flashing Lights ☐
Fluctuation vision ☐
Foreign body sensation ☐
Halos ☐
Regular headaches ☐
Stopped wearing contacts ☐
Stopped wearing glasses ☐
Infection of eye/lid ☐
Itching ☐

Loss of peripheral vision ☐
Loss of vision ☐
Mucous discharge ☐
Redness ☐
Sandy or gritty feeling ☐
Sensitivity to light/glare ☐
Strabismus (cross-eyed) ☐
Tires eyes ☐
Watery eyes ☐

Glasses History (*check all that apply)*

What glasses do you own?

Single Vision ☐
Distance ☐
Reading ☐
Progressive Lens ☐
Bifocals ☐

Sunglasses ☐
Backup Pair ☐
Sports Glasses ☐
Safety Glasses ☐

How many hours per day do you use a computer? ____

Check any that apply:

Allergic to nickel ☐
I do not want to wear glasses ☐
Incorrect prescription ☐
Need spare glasses ☐
Need sunglasses with UV ☐
Problems with current glasses ☐
Problems with glare ☐
Problems with night vision ☐

Contact Lens History (*check all that apply)*

What brand of contact do you wear? ________________
How old are your current contacts? ________________
How often do you replace them? ________________
What solution do you use for soaking? ______________
What is your typical wearing schedule? ______________
`

Check any that apply:

I do not wear contacts ☐
Incorrect prescription ☐
Interested in refractive laser surgery ☐
Need spare contacts ☐
Problems with current contacts ☐
Would like to change my eye color ☐

***Referral Info**: How did you learn about our office? (*Circle Appropriate Source*)
Relative / Friend/ HMO Ins / Location/ Doctor Referral/ Internet
Family Member(s) who are patients here: ________________________________
If you are a new patient, who may we thank for referring you? ________________________

“Signature on File”

All patients who come to this office who have major medical coverage in which Drs. Schoenbart/ Handell are participating providers must have a valid “signature on file” stating that you, the patient, authorizes payment of insurance benefits from your insurance company (i.e. Medicare, Empire, Aetna, Oxford, GHI)to Schoenbart Vision Care. This signature on file MUST be dated on or before the date the claims must be submitted.

***INITIALS*: __________**

To help you understand your insurance coverage for this Optometric Eye Examination, we would like you to note the following:

- Most Major medical plans DO NOT cover routine eye examinations. Your insurance coverage is a negotiated contract between you and the insurance company for medical diagnosis.
- An examination is considered routine when no medical diagnosis is present.
- ***If you are coming through a Vision Plan refraction is covered.***
- Your glasses are made and repaired by your vision plan.
- Medicare and many insurance companies DO NOT cover the Refraction part of the eye examination. (The eyeglass prescription portion of the examination)

Your insurance company may not cover the following:
Refraction (the eyeglass prescription) – ($45 and higher depending on complexity)
Contact Lens Evaluation – ($125 - $175 depending on complexity)
Contact Lens Refit into another type of contact lens - astigmatism, bifocal, specialty contacts – ($250-$275 and higher fee depends on the extent of complexity)

All Refraction Charges and Co-Pays are due when services are rendered. Prescriptions Lens Orders will be processed when paid in full

Having read the above, I understand that I will be responsible for these fees. *INITIALS*: ___________

Do we have permission to:		
Text you?	YES	NO
Leave message on your answering machine at home?	YES	NO
Leave message on your place of work?	YES	NO
Discuss your medical condition with any member of your household?	YES	NO
If circled yes, whom:____	Relationship: _______________	

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office at the time of my visit (I.E insurance cards and referrals) and if I do not, I will be responsible for payment that day. The signature below signifies my compliance with this policy. I have also been given an opportunity to review the office HIPPA policies:

Patient Signature Visit 1: ____Date: __________________

Patient Signature Visit 2: ____Date: __________________

Patient Signature Visit 3: ____Date: __________________

Advanced Retinal Scanning Technology Is Now Available at SVC

Heidelberg Spectralis OCT (Optical Coherence Tomography)

Drs. Schoenbart and Handell (following American Optometric Association guidelines) Strongly recommend screening with this new technology if any one of the following applies to you:

- Are you about the age of 40?
- Do you take any systemic medication for health reasons?
- Have you ever been told or are you being treated for <u>hypertension</u>?
- Have you ever been told or are you being treated for <u>diabetes</u>?
- Does your vision seem to change or fluctuate?
- Do you see halos around lights?
- Do you have a lazy eye?
- Do you exercise with free weights or suffer from sleep apnea?
- Do you have a family member with <u>Macular Degeneration</u>?
- Do you have a blood relative with <u>Glaucoma</u>?
- Have you ever been told that you are a <u>Glaucoma Suspect</u>?
- Has a doctor ever treated you or said you have <u>Glaucoma</u>?
- Has your eye pressure been high or border line?
- Have you even been told that you have a “freckle” in the back of your eye?

Glaucoma and Macular Degeneration are leading causes of Blindness in America today. Early detection is essential to preserve vision. Up to now we have relied on taking the pressure of the eye to determine the risk of Glaucoma and direct viewing of the retina to assess for the **Macular Degenerations**. We, at the Schoenbart Vision Care, are proud to remain on the forefront of eye care technology. This new Technology allows us to examine into parts of the eye previously not viewable and as such enable earlier detection and treatment of potentially ***vision threatening*** diseases. These test are fast, painless and ***do not require drops***. The Retina is as thick as one strand of human hair. The retina is made up of <u>10 layers</u> and we are now able to view **ALL** <u>10 layers</u> with this new instrument.

Unfortunately, insurance companies do not pay for these screenings. The fee for this screening is $40.00

I elect to have these important screenings performed to rule out any possible underlining pathology (disease of my eye)

Please circle: **YES / NO / CONSULT WITH DOCTOR**

Patient Signature: ______________________________

Print: ______________________________

Date: ______________________________

ATTENTION ALL PATIENTS!

About Your PRESCRIPTIONS:

- **New York State has mandated that all prescriptions be sent elctronically directly to your pharmacy.**
- **It is <u>your responsibility</u> to provide updated, accurate information on your pharmacy, so we can transmit your prescriptions in a timely manner.**

Thank you for your cooperation and helping us serve you in the best way possible.

Name:____

Date of Birth:____

Pharmacy Name:____

Pharmacy Address:________________________________**Zip Code:**______________