



### PATIENT INFORMATION

\_\_\_ New Patient \_\_\_ Returning Patient

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Male/Female

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Your Social Security No: \_\_\_\_\_ Your Employer: \_\_\_\_\_

Your Pharmacy: \_\_\_\_\_ Phone/Location: \_\_\_\_\_

Referred by:  Primary Care Physician  Optometrist  Friend/Relative  Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

#### Medical Insurance (if applicable)

Plan Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_

#### Vision Insurance (if applicable)

Plan Name: \_\_\_\_\_ ID/SS#: \_\_\_\_\_

#### NOTIFICATION OF PATIENT RESPONSIBILITY FOR FEES

Some procedures, such as routine eye exams, measuring for glasses, contact lens fitting, special testing, cosmetic procedures and refractive surgeries, **MAY NOT BE COVERED BY INSURANCE.**

**Payment of these services is your responsibility and must be paid for on the date of service.**

If you have routine vision coverage, or think that you may be covered, please notify the receptionist on or before the date of service. This is necessary for us to comply with the terms of your plan.

While we make every effort to verify your coverage and file your insurance claim, the insurance company has the right to deny your claim. Should we receive notification that your claim has been denied for lack of coverage for the service, **payment of services is your responsibility.**

Assignment and Release: I request that payment of authorized Medicare or private insurance benefits are made on my behalf to Samuel J. Yankelove, M.D for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS), private insurance and their agents any information needed to determine these benefits or benefits payable for related services. This signature will be an "on file" authorization to file future forms with Medicare and other insurance companies and for the treatment of myself and/or my minor children. I am financially responsible for non-covered services.

#### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print name: \_\_\_\_\_



### Patient Health Information

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Please check below:

- I am interested in wearing contact lenses
- I would like more information on surgery that may reduce my need for glasses or contact lenses
- I am interested in surgical correction of  Cataracts  Glaucoma

Are you having any of the symptoms below:

- |                          |                          |                                 |                          |                          |
|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| Yes                      | No                       |                                 | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision with glasses     | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Halos or glare                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading street signs | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor side vision                | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Flashes in vision               | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Night blindness                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                                 | <input type="checkbox"/> | <input type="checkbox"/> |

Other, please list: \_\_\_\_\_

Do **YOU PERSONALLY** have a history of any of the conditions listed below:

- |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes                      | No                       | Yes                      | No                       | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please check if there is any **FAMILY** history of:

- Glaucoma  Retina Disease  Other, please list: \_\_\_\_\_
- Cataracts  Diabetes

List all medications you are currently taking, including over the counter medications: \_\_\_\_\_

What eye drops are you currently using? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ Please list: \_\_\_\_\_

Please list any previous eye surgeries or injuries to the eye: \_\_\_\_\_

- Do you smoke? \_\_\_\_\_ How much and how long? \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ Amount and frequency? \_\_\_\_\_
- Are you pregnant? \_\_\_\_\_

Present visual correction:  Glasses:  Bifocal  Trifocal  Reading  
 Contact lenses:  Rigid gas permeable  Soft  Disposable  Toric  Bifocal  
 Are you pleased with your current prescription?  Yes  No If No, why? \_\_\_\_\_

Patient Signature \_\_\_\_\_

Tech Initials \_\_\_\_\_