PATIENT DATA SHEET

Date_____ Emp. Initials_____
Name: Last_____First_____MI____Age_____ Se: M / F

Birth Date_____/_____/_____ Home Ph_____ Work Ph_____

Address_____Apt#_____

City_____ State_____ Zip_____ SSN_____-_____-_____

Employer_____Occupation_____

Work Address_____ City_____

State_____ Zip_____ Email_____

Marital Status: S M P Spouse's Employer_____

If patient is a child, Name of Parent/Guardian: _____

PHARMACY_____ **PHONE**_____

PRIMARY PHYSICIAN_____**PHONE**_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

INSURED/PATIENT INFORMATION
Primary Insurance_____ Insurance Phone#_____

Name of Insured_____ Relationship to patient_____

ID#_____Group#_____

Insured's Employer_____Phone_____

Date of Birth_____ SSN_____-_____-_____

Secondary Insurance_____Phone_____

Name of Insured_____ Relationship to patient_____

ID#_____Group#_____

Date of Birth_____ SSN_____-_____-_____ Work phone_____

Consent for Treatment (Under 18 years of age):

I, _____, the parent/guardian of the above stated patient, give consent to authorize any treatment deemed necessary by Dr. Lina Barry and/or Dr. Gavin Cohen.

Signature _____ Date_____

HEALTH HISTORY

PATIENT NAME _____ **DATE** _____

YES NO

Y N Lung Disease-Type _____
Y N Kidney Disease _____
Y N Arthritis _____
Y N Diabetes _____# of Years_____
Y N Neurological Disease _____
Y N Migraines _____
Y N Psychiatric Disorder_____
Y N Nervous Disorder _____
Y N Heart Disease _____
Y N Gastrointestinal Disease-Type_____
Y N High Blood Pressure ____# of Years_____
Y N Scarring/Keloids _____
Y N Are you Allergic to latex, rubber (Balloons)?
YOUR MEDICAL DOCTOR _____

YES NO

Y N Head or Spinal Injuries _____
Y N Seizures, Convulsions, Fainting _____
Y N Temporal Arteritis _____
Y N Carotid Artery Disease _____
Y N (Women) Are you pregnant or nursing?_____
Y N Stroke _____
Y N HIV/AIDS _____# of years_____
Y N Extensive Confinement from Illness/Injury_____
Y N Permanent Defect from Illness, Disease/Injury_____
Y N Suffering from any other Disease _____
Y N Do You Smoke? #___Packs per__Day__Week__Mo
Y N Do You Drink? #___ per____Day ___ Week ___Mo
Y N Are You Allergic to bananas, pears, avocado, chestnuts?
Y N Do You Live Alone?

Please List All Medications You Are Currently Taking

_____
_____
_____

Please List all Medications Allergies

_____
_____
_____

Have You Been Diagnosed With or Treated for Any of the Following:

Y N Cataracts
Y N Crossed Eyes
Y N Retinal Disease
Y N Injury _____
Y N Corneal Disease
Y N Glaucoma
Y N Iritis
Y N Other Eye Disorders _____

Cataract Surgery Date _____Right Eye _____Left Eye
Do you have a Lens Implant? Y N
Other Eye Surgery/Date _____Right Eye _____Left Eye
Type of Eye Injury (if any) _____

Has any Family Member (Mother, Father, Sisters, or Brothers) Been Treated for the Following?

Y N Glaucoma _____
Y N Cataracts _____
Y N Macular Degeneration _____
Y N Diabetic Retinopathy _____
Y N Diabetes _____
Y N Stroke _____
Y N Retinal Detachment _____
Y N Corneal Disease _____
Y N Retinitis Pigmentosa _____
Y N Other Eye Problems _____
Y N Heart Disease _____
Y N Other Health Conditions _____

Please List any Previous Surgeries and their Date:

_____
_____
_____

Tech. Signature _____

STATEMENTS OF FINANCIAL RESPONSIBILITY:

Please read the following carefully:

Vision plans do not cover the treatment and management of medical eye conditions (for example: dryness, red eye, etc.). If you present with a medical problem or the doctor finds a medical problem, **your major medical insurance and/or you will be liable for the fees for your visit.**

For reimbursement, I authorize my insurance policy to pay the provider directly. I understand that should my insurance company

- Fail to remit a payment, or
- Remits an insufficient payment, or
- Fails to remit a payment within 60 days from date of service,

I will be responsible for all charges incurred.

Patient signature_____ Date_____

RETURN POLICY:

Please understand that due to the nature of customizing ophthalmic lenses, we have a 30 day return policy should there be any concerns or complications. After this 30 day period, we cannot be responsible for any adjustments or changes that need to be made. Frames have a 90 days warranty against any manufacturer defects. Lenses have a 12 month replacement warranty.

Contact lens exam and all professional fees are non-refundable.

Patient signature_____ Date_____

NOTICE OF PRIVACY PRACTICES:

Our notice of privacy practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. By signing this form you consent to our use and release of protected health information as described in our notice. You have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

Patient Name (print) _____

Signature _____ Date_____