smileneyecare

Fredric I. Smilen O.D.

Welcome to our office

Patient Information

Mr. Mrs. Ms. Rev. Dr. Miss	Last name:	First name:	Middle:	Sex:	Birthdate: / /	Age:
Street address:		City:	State:	Zip:	Home Phone: ( )	
Occupation:	Employer:		Work Phone: ( )		Email address(for yearly recall only):	
Social Security no:	Cell Phone: ( )		Vision Care Plan:		Medical Insurance/ ID #	

Patient History

1. Date of last eye exam: Age of present glasses: Type: Distance/Computer/Reading/ Bifocal/Progressive
2. Main reason for today's visit:
3. Last time eyes were dilated? Retinal photos ever taken? ____Y____N
4. Please list all current medications and eye drops:

5. Please list allergies to medications and/or eye drops:
6. Please list any eye injury or surgery and dates:
7. Do you or any blood relatives suffer from the following:

❑ Asthma	❑ Heart Disease
❑ Cataracts	❑ Hypertension
❑ Diabetes	❑ Macular Degeneration
❑ Eye or Eyelid Cancer	❑ Retinal Detachment
❑ Glaucoma	❑ Thyroid Disease

8. Do you use artificial tears? How often? Do they relieve the symptoms? _____Y _____N
9. Do you wear contact lenses? Type: Soft/Gas Permeable/Disposable/Colors/Dailies/Overnight/Bifocals/Mono-Vision
10. Are you considering Laser Vision Correction? Do you rub your eyes frequently? _____Y _____N
11. Name of Primary Care Physician:
12. Sports and hobbies: Do you smoke? ____Y____N
13. Do you like to spend time outdoors? ____Y____N Do you wear sunglasses or Transitions? ____Y____N
14. Bothered by glare? ____Y____N Do you have computer glasses? ____Y ____N
15. Would you like us to email to you a copy of ***Recommendations for Optimal Eye Health?*** ___Y___N
16. Any other medical issues the doctor should be aware of?

Acknowledgements

I agree to be responsible for my bill and any fees incurred in collecting payment for professional services.

Signature_____ ***Date***_____

I certify that the insurance information provided by me is accurate. I authorize the use of this information in helping me obtain payment for the services provided to me. I authorize payment directly to my doctor.

I understand that the accuracy of this information is my responsibility. I also acknowledge all fees for services and materials provided to me are my responsibility. I agree to pay all fees for services or materials should my insurance company reject the claim for any reason.

Medicare pays for 80% of covered services, but does not pay for routine vision examinations or the refraction portion of any eye examination. In addition, some ancillary testing may not be covered. By law we are obligated to collect the remaining 20%, unmet deductibles, and amounts for uncovered services.

Signature_____ ***Date***_____