EYE OPTIONS PATIENT INFORMATION Date____/____/_____

Patient's name (please print)_____M F_ DOB ____/____/_____

Street address_____City_____State_____Zip_____

Home phone(____)_____Work phone(____)_____Ext_____ Occupation_____

Cell Phone(_____)_____Ok to text Y N Email_____@_____

Emergency contact/Phone number_____

SS#_____-____-_____ Marital status S M D W O Spouse's name _____Spouse's SS#_____-_____-_____

Primary health Ins _____ID #_____ Group#_____

Secondary Health Ins_____ID#_____Group#_____

Routine Eye Care Ins _____ID#_____ Group#_____

Allergies? (Please list)_____

List medications you are taking_____
_____

Eye information

List any eye surgeries_____When?_____
Have you had any eye injuries? Y N If yes, what kind? _____When?_____
Have you Glaucoma? Y N, Dry Eyes? Y N, Cataracts? Y N, Blurred vision? Y N, Other_____

Medical History

What is your general health?_____
Have you any problems with any of systems or conditions (circle all that apply)

High blood pressure	Y N	Diabetes	Y N	Asthma	Y N	Emphysema	Y N	Bronchitis	Y N
Stroke	Y N	Thyroid	Y N	Cancer	Y N	Arthritis	Y N	Cholesterol	Y N
Heart disease	Y N	Muscle	Y N	Nerve	Y N	Blood	Y N	Mental	Y N
Headaches	Y N	Other_____							

Do you use tobacco? Y N, Alcohol? Y N, Other substance(s)?_____

Family History

Retinal problems	Y N	Glaucoma	Y N	Cataracts	Y N	Lazy Eye	Y N	Cancer	Y N
Heart disease	Y N	Diabetes	Y N						

Other_____

Name of family or referring Doctor _____Last visit ____/_____/_____

Note: All professional services are charged to the patient. Necessary forms will be completed to help expedite Insurance Carrier payments. However, the patient is responsible for all fees, regardless of Insurance coverage. It is also customary to pay for services when rendered.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder_____DOB_____/_____/_____SS#_____/_____/_____

I request that payment of authorized Medicare/Other Insurance company benefits be made to me or my behalf to Eye Options/Dr. Darryl Levine for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social security Administration and Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Co. claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Section 1128B of the Social Security Act and 31 U.S.C.3801*3812 provides penalties for withholding this information

SIGNATURE_____DATE____/____/_____