

WELCOME TO DRS. SHUSTOCK, LEE & DOMNITCH'S OFFICE

Thank you for the opportunity to provide your eyecare. Please tell us about yourself.

PLEASE PRINT

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Phone Home (____) _____ Cell (____) _____ Work (____) _____
E-Mail: _____
Date of Birth ____/____/____ Age ____ Sex M F Marital Status _____ Soc Sec # _____
Employer / Occupation _____ School Grade or Year (if attending) _____
Insurance _____ Policy # / Member _____
Spouse name _____ Spouse's Occupation / Employer _____
Family Members _____ Age _____ Age _____
For Children, Mother's Name _____ Father's Name _____
Local person and phone number to notify in case of emergency _____
Date of last eye exam _____ Name of the Doctor _____ Primary Care Physician _____

EYE HISTORY

Do you or does anyone in your immediate family have a history of the following?

	No	Self	Family		No	Self	Family
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any eye injuries or surgeries? Yes No If yes, please explain _____

HEALTH HISTORY

Your overall health affects the health of your eyes. Many systemic conditions can have ocular effects. To ensure proper care, our doctors and many insurance companies require a health and vision history from our patients as part of their eye examination.

Do you or does anyone in your immediate family have a history of the following? Please check all that apply.

	No	Self	Family		No	Self	Family
Neurologic (Headaches, migraines, seizures, MS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones, joints, muscles (arthritis, osteoporosis, chronic fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood, lymphatic (high cholesterol, anemia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (diabetes, thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (anxiety, depression, insomnia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardio-vascular (heart, high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastro-intestinal (stomach ulcers, intestinal disorders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Breast, prostate, skin or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases (Hepatitis, HIV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin (rosacea, eczema, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genito-urinary (kidney, bladder, prostate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Do you take medications? Yes No If yes, please list all medicines you are currently taking including vitamins, BCP's, over the counter drugs, etc. _____

Are you allergic to any medications? Yes No If yes, please specify allergy and what happens _____

Do you have seasonal or environmental allergies? Yes No If yes, please specify _____

Women: Are you pregnant? Yes No If yes, what's your due date? _____

1. What is your reason for visiting our office today? Routine Other (please specify) _____

Are you interested in information about preventive ocular health care? Yes No

2. Do you wear glasses? Yes No Please list any problems with your current glasses _____

3 Do you have backup eyeglasses? Yes No

4. Do you wear contact lenses? Yes No If yes, what type? Soft Gas Permeable Daily Wear Extended Wear

5. Have you ever worn contacts in the past? Yes No If yes, why did you stop _____

6. Are you interested in contacts? Yes No If yes, circle all that apply

Soft Gas Permeable Daily Wear Extended Wear Tinted Bifocal

7. Do you experience any visual/ocular discomfort during or after computer work? Yes No

8. To better meet your visual needs, please list any activities, sports or hobbies you may have: _____

9. Are you interested in learning more about laser vision correction? Yes No

Laser Vision correction is now available to correct nearsightedness, farsightedness and astigmatism. During your examination, we will determine if you are a candidate for this procedure. If you wish to proceed with Laser Vision Correction, we will assist you in coordinating all the necessary steps required for the procedure.

10. What / Who may we THANK for referring you to our office? _____

SECTION I: FINANCIAL POLICY

1. Payment is due in full at the time of professional service. We accept cash, checks, American Express, Mastercard, Visa and Discover credit cards. A service charge of 1.50% per month will be added after 30 days. There is a minimum service charge of \$1.50.

2. There is a \$25.00 charge for returned checks.

3. If you have eyecare insurance: As a courtesy to our patients, we try to verify your benefits. However, there are a multitude of plans and some are very complex. Verification is not a guarantee of payment by the insurance company or a release of the patient's legal obligation for any part of the total bill. As a subscriber, you are responsible for knowing the benefits and limitations of your particular plan.

4. In most cases, contact lenses are not considered "medically necessary". Any tests that are performed to determine or update a contact lens prescription will not be covered by most insurance companies and will be the responsibility of the patient.

5. It is the patient's responsibility to provide Focus Eyecare Center P.C. with the appropriate referral form for any services that require such forms. It is the patient's responsibility to pay for any unpaid claims that are denied because a correct referral was not provided.

Your signature indicates that you have read and agree to the policies listed above.

Signature: _____ Date: _____

SECTION II: PATIENT INSURANCE AUTHORIZATION

I hereby authorize Focus Eyecare Center P.C. to file all covered benefits on my behalf. I request payment from my insurance company to be made either to me or on my behalf to Focus Eyecare Center P.C. (If eligible for Medicare, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Focus Eyecare Center P.C. for any services I have received. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services Administration and its agents any information needed to determine these benefits or benefits payable for related services.)

I certify that the information I have recorded with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. I authorize Focus Eyecare Center P.C. to release and/or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree, that regardless of my insurance status, I am ultimately responsible for the payment of any products or services that I have received. Should timely payment on this account not be made, I authorize Focus Eyecare Center P.C. to retain the services of any attorney to assist with collection of any outstanding balance. Any expenses incurred by such action become an additional liability for which I assume responsibility.

Signature: _____ Date: _____

SECTION III: FOR OUR VSP PATIENTS

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request, to VSP for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to: www.vsp.com. VSP updates the Patient Confidentiality Policy periodically and reserves the rights to make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature: _____ Date: _____