

Welcome To Our Office

Today's Date _____

Last _____ First _____ MI _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

Home Phone _____/Cell _____

Work Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

What is the major purpose of this visit?

Our goal, through continuing medical education and technological awareness, is to provide our patients the best eye health care available.

We will continually use state of the art instruments and optical products to maximize your vision and to keep you at the forefront of style and function.

We will strive to exceed your expectations in service and value while always being aware that your long term visual well-being is our responsibility.

**Dr. Scott P. Feldman
& Staff**

Notice of Privacy Practices:

I acknowledge that I have received the Notice of Privacy Practices from Dr. Scott P. Feldman

Signature _____ date _____

Insurance Authorization

I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to...

Dr. Scott P Feldman, O.D.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits of the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

Signature _____ date _____

Please note that insurance does NOT cover the Contact Lens Evaluation and Follow Up.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

Lifestyle Questions

Do you.....(check box if your answer is yes)

..work at a computer? If yes, hours per day ____.

..spend time outdoors? How much? ____Hrs/week

..prefer not to wear your glasses at times?

..have children? Ages? _____

..currently wear contact lenses?

..want to be evaluated for refractive laser surgery?

Glasses owned:

Single vision Bifocals Safety Glasses

Computer Sports Glasses

Progressive Sun Glasses

Sports in which you participate _____

Hobbies _____

If you currently wear eyeglasses, do your backup eyeglasses have your correct prescription? Yes No

If you wear bifocals, do the lines or head tilting bother you? Yes

No

Are your sunglasses your current prescription? Yes No

Have you ever tried contact lenses? Yes No

If you currently wear contact lenses, do your glasses have your correct prescription? Yes No

No

Are you satisfied with the vision and comfort of your contact lenses? Yes No