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

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes