

Poughkeepsie Optometry, P.C.  
Welcome to our office

**Patient:** \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F M  
(Last) (First)  
Prefer to be called: \_\_\_\_\_ Marital Status: S M W D Name of spouse: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ WorkPhone:(\_\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
If student, grade/year \_\_\_\_\_ School: \_\_\_\_\_ Soc.Security# \_\_\_\_\_

**Person responsible for payment:** \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
StreetAddress: \_\_\_\_\_ HomePhone:(\_\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ WorkPhone:(\_\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Soc.Security# \_\_\_\_\_

**In case of emergency:** name of relative not living with you: \_\_\_\_\_ Relation: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone:(\_\_\_\_\_) \_\_\_\_\_

**Insurance Information:** Please list BOTH Vision Insurance and Medical Insurance(present both cards to the receptionist). Medically related eye examinations and procedures are covered under medical insurance while routine eye exams are covered under vision insurance.

VSP(VisionServicePlan)     Eyemed     Aetna     Oxford  
 Davis Vision     Medicare     BlueCrossBlueShield     CDPHP  
 CSEA     MVP     Wellcare     United Health Care  
 Other: \_\_\_\_\_

**Please note:** If your insurance requires a referral, it must be obtained prior to your appointment. You will be responsible for payment if your insurance refuses to pay due to failure to obtain referral. Any applicable co-payments will be collected at the time of the exam. Patient acknowledges that should they not pay this account and it is assigned to a collection service, he/she will be liable for any collection fees charged by the agency plus any other collection costs.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Medicare Authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Poughkeepsie Optometry for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**Signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

Please answer/fill out all of the following questions to the best of you ability:

Who is your primary care physician? \_\_\_\_\_ City: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_ friend/relative \_\_\_\_\_  
 \_\_yellow pages \_\_ insurance list \_\_ reputation \_\_ established patient \_\_ professional referral  
 \_\_ other: \_\_\_\_\_

What is the reason for this appointment? \_\_\_\_\_

Approximate date of last eye exam: \_\_\_\_\_ Previous doctor's name: \_\_\_\_\_

Have you ever worn glasses? \_\_ Yes \_\_ No Contact lenses \_\_ Yes \_\_ No \_\_ soft \_\_ rigid gas permeable  
 \_\_ daily wear \_\_ over night

I would like more information about: \_\_ contact lens options \_\_ laser vision correction \_\_ dry eye treatment options  
 \_\_ no line bifocals \_\_ computer glasses

<p><b>Personal Eye/Ocular History</b></p> <p>Y / N Glaucoma                      Y / N Flashing lights          Y / N Cataracts                      Y / N Floating spots          Y / N Macular degeneration      Y / N Itching          Y / N Amblyopia/lazy eye          Y / N Red          Y / N Stabismus/eye turn          Y / N Burning          Y / N Iritis/uveitis                  Y / N Tear          Y / N Retinal tear/detachment    Y / N Dry          Y / N Eye surgery          Y / N Eye injury          Other: _____</p>	<p><b>Personal Health History</b></p> <p>Y / N High blood pressure          Y / N Diabetes          Y / N Thyroid          Y / N Stroke          Y / N Heart disease          Y / N Cancer          Y / N HIV/AIDS          Y / N Asthma          Y / N Allergies          Other: _____</p>
<p><b>Family Eye/Ocular History</b></p> <p>Y / N Glaucoma          Y / N Cataracts          Y / N Macular degeneration          Y / N Lazy eye          Y / N Retinal detachment          Y / N Blindness          Other: _____</p>	<p><b>Family Health History</b></p> <p>Y / N High blood pressure          Y / N Diabetes          Y / N Heart disease          Y / N Stroke          Y / N Cancer          Other: _____</p>
<p>List ALL <b>Medications</b> you are presently taking (including <u>non-prescription</u> drugs):</p> <p>_____</p>	<p>List all <b>allergies</b> you have to medications:</p> <p>_____</p>
<p><b>Personal social history:</b></p> <p>Y / N Smoke                              Y / N Other substances          Y / N Drink alcohol                      Y / N Drive a car</p>	

Patient ocular and health history completed: Today' date \_\_\_\_\_

Updated: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_  
 Updated: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_