FAMILY VISION CARE ASSOCIATES, LLP

PATIENT HISTORY QUESTIONNAIRE

Today's Date:_____

1. PERSONAL INFORMATION

Last Name:_____ First Name:_____ MI:_____

Title: Mrs. _____ Ms. _____ Miss _____ Mr. _____ Dr. _____ Other: _____

Street Address:_____

City:_____ State:_____ Zip_____

Home Phone #:_____ Work Phone #_____ Ext.:_____

Cell Phone # _____ Email: _____

PLEASE CIRCLE YOUR CONTACT PREFERENCE: PHONE TEXT E-MAIL

Date of Birth:_____ Social Security No._____

Occupation:_____ Employer:_____

Interests/Hobbies:_____

Whom may we thank for referring you?_____

[Doctor – Another Patient – Vision Care Plan, etc.]

2. EYE HEALTH HISTORY:

Date of last eye exam?_____ Name of Doctor:_____

Have you had any eye operations? Y/N Type:_____ Date:_____

Have you had an eye injury? Y/N Kind:_____ Date:_____

Do you wear glasses? Y/N If yes, circle all that apply: all the time – occasionally – reading – driving -- TV

Describe any problems you have with your glasses:_____

_____

Do you wear contacts? Y/N Type:_____ Hours/Day_____

Describe any problems you have with your contacts:_____

_____

Please indicate whether you have had any of the following:

Blurred Vision-Distance	Y/N	Bloodshot Eyes	Y/N	Temporary Loss of Vision	Y/N
Blurred Vision- Near	Y/N	Floaters or Spots	Y/N	Seeing Halos	Y/N
Eye Strain	Y/N	Seeing Flashes	Y/N	Twitching Eyelid	Y/N
Headaches	Y/N	Double Vision	Y/N	Eye infection	Y/N
Dry Eyes	Y/N	Light Sensitivity	Y/N	Crossed Eyes	Y/N
Watering Eyes	Y/N	Night Vision, Poor	Y/N	Cataracts	Y/N
Burning Eyes	Y/N	Dizzy Spells	Y/N	Glaucoma	Y/N
Itching Eyes	Y/N	Discharge from Eyes	Y/N	Color Vision, Poor	Y/N

3. MEDICAL INFORMATION:

When was your last general health exam?_____ Name of family doctor?_____

List any medications you are currently taking:_____

_____

List any eye drops you are currently using:_____

Do you have any allergies to medication? _____

Do you have other allergies?_____

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other Substances?_____

3. MEDICAL INFORMATION (Cont'd):

Please indicate if you or a blood relative has had any of the following problems:

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	Y/N	Y/N	Heart Condition	Y/N	Y/N
Arthritis	Y/N	Y/N	Hepatitis (Type ___)	Y/N	Y/N
Artificial Valve	Y/N	Y/N	High Blood Pressure	Y/N	Y/N
Artificial Joint	Y/N	Y/N	Kidney Disease	Y/N	Y/N
Asthma	Y/N	Y/N	Lazy Eye	Y/N	Y/N
Bleeding	Y/N	Y/N	Migraine Headaches	Y/N	Y/N
Blindness	Y/N	Y/N	Pacemaker	Y/N	Y/N
Cancer	Y/N	Y/N	Poor Color Vision	Y/N	Y/N
Cataracts	Y/N	Y/N	Retinal Disease	Y/N	Y/N
Chemical Dependency	Y/N	Y/N	Rheumatic Disease	Y/N	Y/N
Diabetes	Y/N	Y/N	Shingles	Y/N	Y/N
Drug Sensitivity	Y/N	Y/N	Skin Conditions	Y/N	Y/N
Emphysema	Y/N	Y/N	Stroke	Y/N	Y/N
Epilepsy	Y/N	Y/N	Thyroid Conditions	Y/N	Y/N
Eye Surgery	Y/N	Y/N	Tuberculosis	Y/N	Y/N
Glaucoma	Y/N	Y/N	Turned Eye	Y/N	Y/N
Hay Fever	Y/N	Y/N			

4. INSURANCE INFORMATION

Insurance Company:_____

[Medicare –Aetna– Blue Cross/Blue Shield, etc.]

Name of Primary: Last:_____ First:_____

Date of Birth:_____ Address:_____

Name of Insured: Last:_____ First:_____

Insurance I.D.#:_____ Group#:_____

FINANCIAL POLICY

All patient fees, that we anticipate not to be covered by insurance, will be collected at the time of service. Materials will only be ordered after we have received a fifty (50%) percent deposit and those materials cannot leave the office until they are paid in full. It is expected that your account will be kept current. We will take any necessary measures to collect any amount past due over 120 days.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign directly to Dr. Bernstein all my insurance benefits payable by said carrier(s). I understand that Dr. Bernstein will submit to my insurance carrier(s) for the services rendered today. I understand that I am responsible for obtaining any referrals required prior to the services being rendered. I further understand that I am financially responsible for all charges whether or not payable by insurance and am also responsible for payment of any services deemed "not covered" under the terms of my benefit contract. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship_____ Date_____

Directions

From Cross Westchester Expressway (Route 287)

Westbound: Take Exit 9N-S. At the end of the ramp you will be on Westchester Avenue (westbound). At the fifth traffic light, make a left turn onto the William Butcher Bridge. After going through the traffic light (on the far side of the bridge) proceed about 50 feet and make a left turn into the parking area. Go past the building entrance and on your right will be parking spaces for Family Vision Center.

Eastbound: Take Exit 8E. At the end of the ramp you will be on Westchester Avenue (eastbound). Go to the second traffic light (William Butcher Bridge) and make a right turn. Proceed about 50 feet and make a left turn into the parking area. Go past the building entrance and on your right will be parking spaces for Family Vision Center.

From Interstate 95

Take Exit 21 for the Cross Westchester Expressway (287 West - towards the Tappan Zee Bridge). Follow directions for "*From Cross Westchester Expressway - 287 West*".

From Route 684

Take 684 South to the end (the Exit will be marked I-287 New England and White Plains). Once on the exit ramp, bear right and follow the signs for White Plains. The exit ramp will feed onto Westchester Avenue (westbound). Go to the first traffic light and turn left onto the William Butcher Bridge. After going through the traffic light (on the far side of the bridge) proceed about 50 feet and make a left turn into the parking area. Go past the building entrance and on your right will be parking spaces for Family Vision Center.

From Hutchinson River Parkway

Take parkway to Exit 26W (Westchester Avenue - Cross Westchester Expressway, Route 287W). The exit ramp will put you on Westchester Avenue (westbound). Go to the fourth traffic light and turn left onto the William Butcher Bridge. After going through the traffic light (on the far side of the bridge) proceed about 50 feet and make a left turn into the parking area. Go past the building entrance and on your right will be parking spaces for Family Vision Center.

From Mamaroneck Avenue

Take Mamaroneck Avenue to Bryant Avenue. Take Bryant (towards White Plains H.S.). At the second traffic light (opposite the athletic fields) make a left into White Plains Office Park. Proceed through two stop signs and then bear left at the sign for #701. Just before you get to the front of the building there will be parking spaces for Family Vision Center on your left.

701 Westchester Avenue
White Plains, NY 10604
(914) 948 - 0304