

# Family Vision Care – Adult Form

## Patient Information

Today's Date: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI \_\_\_\_\_  
 Title: Mrs. \_\_\_ Ms. \_\_\_ Miss \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Other \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_  
 Driver's License #: \_\_\_\_\_  
TO BE USED FOR NY DMV LICENSE RENEWAL ONLY  
 Sex: M F Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Please circle your contact preference: PHONE TEXT E-MAIL  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Whom may we thank for referring you to our office?

[Doctor – Another Patient – Insurance, etc.]

## Insurance Information

Primary Medical Insurance: \_\_\_\_\_  
 Member ID #: \_\_\_\_\_  
 Name of Primary: \_\_\_\_\_  
 Primary Date of Birth: \_\_\_\_\_  
 Primary SSN: \_\_\_\_\_  
 Secondary Medical Insurance: \_\_\_\_\_  
 Member ID #: \_\_\_\_\_

## Eye Health History

Last eye exam date: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
 Have you had eye operations?  Yes  No  
 Type and date: \_\_\_\_\_  
 Have you had an eye injury?  Yes  No  
 Kind and date: \_\_\_\_\_  
 Have you had vision therapy?  Yes  No At what age? \_\_\_\_\_  
 With whom and for what? \_\_\_\_\_  
 Do you wear glasses?  Yes  No  
 If yes...  all the time  occasionally  TV  driving  reading  
 Describe any problems/ frustrations you have with your glasses: \_\_\_\_\_  
 \_\_\_\_\_  
 Do you wear contacts?  Yes  No  
 Brand: \_\_\_\_\_ Hours/Day: \_\_\_\_\_  
 Describe any problems/ frustrations you have with your contacts: \_\_\_\_\_  
 \_\_\_\_\_

## Lifestyle Questions

- Do you...(check box if answer is yes)**
- ..work at a computer? \_\_\_\_\_ Hrs/day
  - ..think you might benefit from thinner, lighter lenses?
  - ..spend time outdoors? \_\_\_\_\_ Hrs/week
  - ..have prescription sunwear?
  - ..prefer not to wear your glasses at times?
  - ..experience bothersome glare or reflection, particularly when night driving?
  - ..have more than 1 pair of current prescription eyewear?

**Please indicate hobbies and interests:**

**Do you use any of the following:**

- alcohol  Yes  No
- other controlled substance  Yes  No
- cigarettes/tobacco  Yes  No
- If no, prior smoker?  Yes  No
- If yes, how much \_\_\_\_\_

## Current Eye Health

Are you currently experiencing any of the following?

- Blurred Vision - Distance
  - \_\_\_ With Glasses
  - \_\_\_ With Contacts
  - \_\_\_ Without Correction
- Blurred Vision - Near
  - \_\_\_ With Glasses
  - \_\_\_ With Contacts
  - \_\_\_ Without Correction
- Burning
- Cataracts
- Corneal Abrasions
- Crossed Eye/ Eye turn
- Discharge from Eyes
- Double Vision
- Dry Eyes
- Eye Infection
- Eye Injury
- Eye Strain
- Floaters/ Spots
- Glare/ Halos
- Glaucoma
- Headaches
- Itchy Eyes
- Light Sensitivity
- Poor Color Vision
- Poor Night Vision
- Seeing Flashes
- Temporary Loss of Vision
- Watery Eyes
- Other: \_\_\_\_\_

The information in this confidential case history form is critical to the evaluation of your vision and health.

### Medical History

Name of family physician: \_\_\_\_\_ City: \_\_\_\_\_

Last Physical Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are you pregnant or nursing?  Yes  No

List any medications you are currently taking and for which condition (Rx or over the counter): \_\_\_\_\_

List any allergies to medications: \_\_\_\_\_

**Have you ever been diagnosed or treated for the following health problem? If yes, please explain:**

- Allergy (Seasonal, Pet, Food) \_\_\_\_\_
- Cancer \_\_\_\_\_
- Cardiovascular (High Blood Pressure, Cholesterol, Heart Surgery) \_\_\_\_\_
- Ears, Nose, Mouth, Throat (Sinus, Dry Mouth/ Throat) \_\_\_\_\_
- Endocrine (Thyroid, Diabetes) \_\_\_\_\_
- Gastrointestinal (Constipation, Ulcer, Reflux) \_\_\_\_\_
- General (Anemia, Fatigue, Fevers, Weight loss/gain) \_\_\_\_\_
- Genitourinary (Incontinence, Bladder, Kidney Stones) \_\_\_\_\_
- Hematologic/ Lymphatic (Blood Disorders) \_\_\_\_\_
- Immunologic (Lupus, RA, MS) \_\_\_\_\_
- Injuries, Surgeries, Hospitalization \_\_\_\_\_
- Musculoskeletal (Arthritis, Joint Pain) \_\_\_\_\_
- Neurological (Migraines, Seizure) \_\_\_\_\_
- Psychiatric (Depression, Anxiety, Insomnia) \_\_\_\_\_
- Respiratory (Asthma, Bronchitis, COPD) \_\_\_\_\_
- Skin (Acne, Rashes, Growths) \_\_\_\_\_

Is there a family medical history of any of the following:  No  Yes (Please check boxes)

	Family Member
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Macular Degen.	<input type="checkbox"/> _____

	Family Member
Cancer	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Eye Surgery	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

*Please be sure to bring and provide a government issued ID and current medical insurance card(s) upon arrival. If you need a referral from your insurance plan, please be sure to obtain one prior to your visit. Thank you!*

**FINANCIAL POLICY**

Co-pays will be collected at the time of service. If the patient has a deductible/co-insurance plan, then we will collect \$80 at the time of service and the balance will be billed (or credited) once insurance has paid us. All other patient fees, that we anticipate not being covered by insurance, will be collected at the time of service.

Materials will **ONLY** be ordered after we receive a fifty (50%) percent deposit and those materials **CANNOT** leave the office until they are paid for in full (unless prior arrangements have been made with Dr. Paul or Dr. Andrea).

It is expected that your account will be kept current. If you should have a financial hardship, please speak with Toni Ann who will help you set up a payment plan.

**LATE PATIENT POLICY**

Due to all the extra traffic and traffic issues in the area we are implementing this policy to protect all of our patients.

Please call if you are going to be more than fifteen (15) minutes late, we will be happy to accommodate you by starting your exam but when the next patient comes you will have to go back out to reception and the doctor will complete your exam around the other patients in the schedule. This will allow us to accommodate you without disrupting everyone else's schedule.

Please be advised that if you are one of our last patients of the day it is at the doctor's discretion whether there will be enough time to accommodate you or if you will need to reschedule.

**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