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		Family Member
Blindness	❑ _____	Cancer	❑ _____
Cataracts	❑ _____	Corneal Problems	❑ _____
Diabetes	❑ _____	Eye Surgery	❑ _____
Glaucoma	❑ _____	Heart Disease	❑ _____
High Blood Pressure	❑ _____	Lazy Eye	❑ _____
Macular Degen.	❑ _____	Retinal Problems	❑ _____

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