Welcome to Borodkin Eyecare

Please fill out this form completely to help us serve you better.

PERSONAL INFORMATION:

Last Name____________________________ First Name______________________ MI_____ Today's Date_________________

Address_________________________________Apt/Ste_________City____________________State_____Zip_____________

Social Security Number________________________Birthdate_____________________Email__________________________

Telephone: Home________________________Work___________________________Cell____________________________

Single/Married/Other (Circle one) Emergency Contact:___________________________________Phone_________________

Your (or Parent's) Employer________________________________Occupation____

Spouse's name _______________________Employer _________________________Occupation_______________________

If Student, School or College _______________________________________Grade_________ School Phone_______________

How did you hear about our office? Website___ Yellow Pages__ Insurance List ___Referred by: ________________________

VISION INSURANCE: Please bring all cards with you to each visit.

Name of Insured______________________________ Relationship to Patient ___________ Insured's Birthdate ____________

Insured's ID #________________________________Group # _________________Vision Plan Name____________________

Vision Plan Address________________________________City____________State_____Zip__________Phone____________

MEDICAL INSURANCE: Please bring all cards with you to each visit.

Name of Insured______________________________ Relationship to Patient ___________ Insured's Birthdate ____________

Insured's ID #________________________________Group # _________________Medical Plan Name___________________

Medical Plan Address______________________________City____________State_____Zip__________Phone____________

Has your deductible been met?________ What is your office visit co-payment? ________ Other Insurance? ________**

**If yes, please fill out the following for your secondary plan:
Name of Insured______________________________ Relationship to Patient ___________ Insured's Birthdate ____________

Insured's ID #________________________________Group # _________________Medical Plan Name___________________

Medical Plan Address______________________________City____________State_____Zip__________Phone____________

Has your deductible been met?________ What is your office visit co-payment? ________

VISION AND EYE HEALTH HISTORY:

Date of Last Eye Exam_________________ Previous Eye Doctor ____________________________

What is the reason for today's visit?____

No, you are not done yet, please turn over for page 2 !

Do you where glasses now? If so, circle one: All the time / Distance vision / Near vision / Other______________________

Do you currently wear contact lenses? YES / NO Have you worn contact lenses in the past? YES / NO

Are you interested in wearing contact lenses? YES / NO Type of contact lenses ? ____________________________________

What problems have you had in the past or currently with contact lenses?____

Do you have special hobbies or occupational vision needs?____

Have you had Lasik or other refractive surgery? YES / NO Any interest? YES/ NO

Please check any of the following that YOU have or have had in the past and give details below:

___Eye surgery, injury or trauma ____
___Frequent sensitivity to lights ____
___Frequent floaters or spots in vision ____
___Eye infection or disease diagnosis ____
___Double vision ____
___Eye strain / pain ____
___Frequent Headaches ____
___Eyes that burn, itch, or water frequently ____
___Dry Eyes
___Diagnosis of Cataracts
___Glaucoma ___Family History of Glaucoma
___Macular Degeneration ___Family History of Macular Degeneration
___Retinal injury/disease ___Family History of Retinal Disease

MEDICAL HISTORY: Name of Primary Care Physician:____

Please check all of the following that apply to YOU of YOUR FAMILY history and give details below:

SELF	FAMILY		
____	____	High Blood Pressure	____
____	____	Heart Condition	____
____	____	Thyroid Disease	____
____	____	Lung Disease	____
____	____	Kidney Disease	____
____	____	Gastrointestinal Disease	____
____	____	Diabetes (Age of Onset____)	____
____	____	Allergies to Medications	____
____	____	Allergies (other)	____
____	____	Sinus/Ear/Nose/Throat Issues	____
____	____	Cancer	____
____	____	Other (please specify)	____
____	Frequent Use of Alcohol		____
____	Use of Other Substances		____
____	Use of Tobacco		____
____	Are you pregnant? _____ months		

My current medications are:____
____
____
____

I authorize the release of any medical information necessary to provide the most beneficial and complete eye health and vision examination. I understand that I am financially responsible for all services provided and their respective fees regardless of insurance coverage and payment. I also understand payment is due at the time services are rendered with the exception of amounts assigned to insurances. Furthermore, in the event that collection efforts are needed for these services, I agree that I am also responsible for any and all legal fees, attorneys, and collection charges associated with collection of these amounts.

Signature____Date_________________________