Eye Options Patient Information Date: __ / __ / ____

Patient's Name (please print): _____ DOB: ___ / __ / _____

Gender: M , F , Prefer Not to Specify , Other (please specify preferred pronouns): _____

SS#: _____-_____-_____ Marital Status: *S M D W Other* Occupation: _____

Street Address:_____ City: _____ State: ____ Zip: _____

Home phone: (____) _____ Cell Phone: (____) _____ Texting ok? **Y or N**

Email: _____

Emergency Contact Name: _____ Phone: (____) _____

Insurance Information:

Primary Health Ins: _____ ID# _____

Primary Vision Plan: _____ ID# _____

Health Information:

Allergies? *(please list)*: _____

Medications? *(please list)*: _____

Please list all known medical conditions (i.e. Diabetes, Hypertension, Migraines, etc.): _____

_____

Do you use tobacco? **Y N** , Alcohol? **Y N** , Other substance(s)? _____

Eye Health History:

Date of last eye exam: ___ / ___ / _____ Was your last exam here? **Y N ,** *If N, where?*_____

Eye Surgeries? *(please list with dates)*: _____

Have you had any eye injuries? **Y N** *If Y, please list with dates*: _____

Do you have any of the following conditions *(please circle Yes or No)*:

Glaucoma? **Y N** , Dry Eyes? **Y N** , Cataracts? **Y N** , Blurred Vision? **Y N**

Do you have any other eye concerns? **Y N** *If Y, please list:*_____

Family History *(please circle Yes or No)*:

Retinal problems **Y N ,** Glaucoma **Y N** , Cataracts **Y N ,** Lazy Eye **Y N ,** Cancer **Y N** , Heart disease **Y N** , Diabetes **Y N**

Other Conditions:_____

Name of Primary or Referring Doctor: _____Last visit ___/___/_____

Note: All professional services are charged to the patient. Necessary forms will be completed to help expedite Insurance Carrier payments. However, the patient is responsible for all fees, regardless of Insurance coverage. It is also customary to pay for services when rendered.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder: _____ DOB: _____/_____/_____

I request that payment of authorized Medicare/Other Insurance company benefits be made to me or my behalf to Eye Options/Dr. Darryl Levine for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social security Administration and Centers for Medicare and Medicaid Services (CMS), or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Co. claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Section 1128B of the Social Security Act and 31 U.S.C.3801*3812 provides penalties for withholding this information.

SIGNATURE _____DATE ___/ ___/ _____