DR. STEVEN WEISFELD - OPTOMETRIC PHYSICIAN

PLEASE PRINT AND COMPLETE ALL SPACES OF THE PATIENT QUESTIONNAIRE

Patient's Last Name: _____ First/Middle Name: _____

Street Address: _____ Date of Birth: _____

City_____, State_____, Zip_____ SS#: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext.____

Email Address: _____ Occupation: _____

Sex: M ☐ F ☐ Marital Status: Married ☐ Single ☐ Other ☐

Responsible Party: Self ☐ Other ☐: _____ Relationship: _____

Primary Medical Insurance Co: _____ ID# _____

Do you have Routine Eye Coverage? Y ☐ N ☐ Vision Plan Name:_____ Every: 12mo ☐ 24mo ☐

Insurance Member: Self ☐ Other ☐ Name:_____ D.O.B:_____ SS#:_____

Secondary Medical Insurance Co: _____ ID# _____

Primary Care Physician: _____ Phone: _____

Pharmacy information: _____ Phone: _____

Do you wear spectacles? Y ☐ N ☐ Type: Distance ☐ Near ☐ Progressive/Bifocal ☐

Do you wear contact lenses? Y ☐ N ☐ Type: Hard ☐ Soft ☐ Daily ☐ Astigmatic ☐ Brand:_____

Are you allergic to any medications? Y ☐ N ☐ Please list: _____

Have you ever had any Eye Injury/Surgery? Y ☐ N ☐ Explain:_____

Are you currently using any eye medication? Y ☐ N ☐ List: _____

Do you smoke? Y ☐ N ☐ Former ☐ Do you drink? Y ☐ N ☐ Social ☐

Reason for your visit: _____ Referred by: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Spectacles to submit claims for benefits, services rendered or for services to be rendered.

I, _____ authorize (Insurance Co.)_____

to pay and hereby assign directly to Dr. Steven Weisfeld all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Steven Weisfeld will be credited to my account in accordance with the above said assignment.

I understand that it is my responsibility, as the patient, to convey proper *vision* coverage information. Any insurance rejections do to incorrect information given, will be my responsibility.

Signature: _____ Date: _____

* Privacy Policy: It is the policy of Spectacles that your information will never be rented, sold or provided to another medical practice, or promotional organization without your expressed permission.

Patient Name: _____ Date: _____

Are you currently being treated for any medical condition? ☐ Y ☐ N Please explain: _____

_____

Are you currently using any medications? ☐ Y ☐ N (If you have a printed list, we can make a copy)

Please list:

Medication:	**Strength:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do **you** or your **family** have any history of the following conditions? (check all that apply):

Self	**Family**		**Relationship**
☐	☐	Glaucoma	_____
☐	☐	Cataract	_____
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure	_____
☐	☐	High Cholesterol	_____
☐	☐	Macular Degeneration	_____
☐	☐	Stroke	_____
☐	☐	Thyroid Condition	_____
☐	☐	Crossed/Lazy Eyes	_____
☐	☐	Color Blindness	_____
☐	☐	HIV/Hepatitis	_____
☐	☐	Skin Disease	_____
☐	☐	Loss of Vision	_____
☐	☐	Headaches/Migraines	_____

Do **you** currently have any of the following symptoms? (check all that apply):

- ☐ Blurry Distance/Near Vision
- ☐ Eye Strain/Pain
- ☐ Poor Night Vision
- ☐ Itchy/Burning Eyes
- ☐ Watering
- ☐ Foreign Body Sensation
- ☐ Halos
- ☐ Sandy/Dry Eyes
- ☐ Red Eyes or Styes
- ☐ Floaters
- ☐ Glare/Reflections
- ☐ Light Sensitivity
- ☐ Chronic Eye Infections
- ☐ Flashing Lights
- ☐ Double Vision
- ☐ Sinus Trouble
- ☐ Head Injury

Spectacles Policy on Insurance

It is your responsibility as the patient to know exactly what kind of vision coverage you have and to convey this information to the staff. If we are providers of your insurance, we will only accept your plan if you are covered for a Routine Eye Exam. This is aside from your medical coverage. Insurance cards and PCP referrals (if necessary) must be presented prior to the examination.

Notice of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____