Friedman Ophthalmology and Optometry Building

Including Lasik Vision Correction

Welcome To Our Office

Patient Information

Date:_____ Date Of Birth_____

Patient Name_____ Cell Phone_____

Guardian Name (Under 18yrs) _____ Work Phone_____

Mailing Address_____ City_____ State_____ Zip_____

Email Address_____ Sex: Female____ Male____

Health/Vision Insurance

Vision Insurance Name_____ ID #_____ Group #_____

Medical Insurance Name_____ Primary Member_____

Important Insurance Information

PPO Insurance Name_____ HMO Insurance Name_____ IPA_____

Are you a member of Healthcare Partners? Yes / No Are you a member of Accountable Healthcare? Yes / No

Other Insurance? Medical_____ Medicare_____ Other_____

Referring Doctor's Name_____

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Symptom Check List

Last Name_____ First Name_____ DOB_____

General Medical Information:

- Date of Last Complete General Physical Exam_____
- Doctor's Name_____
- Do you have High Blood Pressure? Yes___ No__
- Diabetes? Yes__ No__ Glaucoma? Yes___ No___
- Any other Medical Conditions? _____, _____, _____.
- Family History of any of Eye disease? _____
- Do you take any medications? Yes__ No__ Any Allergies to Medications? Yes__ No__
- Do you Smoke? Yes__ No__ Did you smoke in the past? Yes__ No___

Vision Information:

- Do you wear protective sunglasses to protect from harmful UV of the sun? Yes__ No__
- Do you wear special designed computer glasses to protect your vision from harmful Blue Rays/ LED monitors? Yes__ No__
- Would you like to eliminate use of eyeglasses or contacts with a safe procedure called Lasik? Yes___ No___
- Would you like information from the Doctor who has experienced procedure? Yes_ No_
- Please fill out form to send results of your examination to your Physician.
- Have you had any Eye Surgery? Yes___ No___ (or) Eye Injury? Yes__ No__
- Do you wear glasses? Yes__ No__ Contact Lenses? Yes___ No___

Patient Signature_____

Retinal Photography:

- Please read attached information on advance Retinal Photography called Eye Screen and ask for information of benefits from this procedure.

Acknowledge of Receipt

Assignment of benefits; Responsibility for Payment. I hereby authorize and request my insurance to pay directly to this office the amount due in my pending claim for vision or medical treatment or services by reason of such treatment or services. I understand that insurance is a private arrangement between myself and the insurance company, and that I am fully responsible for all money due as a result of the services, products, or treatment provided to me by this office.

Signature_____Date_____

Update Email Address: _____