North Shore Optometric Group

Dr. Larina R. Rosa **Dr. Neha P. Sheth**

Please complete all questions on BOTH SIDES of this form

Today's Date: _____

PATIENT INFORMATION

Name: _____ Age: _____ Marital status: _____ Sex: M F

Date of Birth: _____ Social Security Number: _____ Spouse Name: _____

Mailing Address: _____

City, State, Zip: _____ Email: _____

☐ Check box if you would like to receive your next appointment reminder via email

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Employer (or School): _____ Occupation (or Grade): _____

Name of Parent or Guardian (If patient is younger than 18): _____

Family Doctor: _____ Who referred you to our office? _____

Last Eye Exam: _____ Last Medical Exam: _____

Do you wear glasses? Y N Do you wear contact lenses? Y N If no, are you interested in contact lenses? Y N

Are you interested in LASIK? Y N

INSURED INFORMATION (If different from patient)

Name: _____ Relationship to Patient: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

VISION INSURANCE (Eyeglasses, Contact lenses)

Insured Name: _____ Insured SSN: _____ Insured date of birth: _____

Insurance Company: _____

MEDICAL INSURANCE (Medical eye conditions)

Insured Name: _____ Insured SSN: _____ Insured date of birth: _____

Insurance Company: _____ I.D.# _____ Group Number:_____

PLEASE TURN OVER AND COMPLETE SIDE TWO

_____ _____

Doctor's Signature Today's Date

PATIENT'S CURRENT MEDICAL HISTORY

AND REVIEW OF SYSTEMS

Please check all that apply to patient's CURRENT medical and eye history:

o Blurred Vision o Redness o Eye Pain o Eye irritation o Eye ache o Eye itching o Eye burning o Eye dryness o Eye strain o Eye discharge o Excess tearing o Eye or eyelid swelling	o Glare o Painful light sensitivity o Flashes in vision o Floaters in vision o Double vision o Vision dimness/loss o Distorted vision o Loss of side vision o Cataract o Glaucoma o Retinal disease o headaches	o Dizziness o Head injury o Other neurological o Diabetes o Thyroid disease o High blood pressure o Heart disease o Sinusitits o Hayfever or allergies o Skin rashes or lesions o Impaired hearing	o Arthritis o Asthma o Emphesema/bronchitis o Kidney disease o Bladder disease o Bowel disease o Fever, fatigue, weight loss o Anemia or blood disorders o Hepatitis o Emotional or psychiatric o Cancer o HIV/AIDS

OTHER CONDITIONS NOT LISTED ABOVE: _____

Female Patients: Are you pregnant or nursing? Y N _____

CURRENT MEDICATIONS: None / _____

ALLERGIES: None / _____

PATIENT'S PAST MEDICAL HISTORY (Please list all major injuries, surgeries or past medical conditions)

_____

FAMILY HISTORY (Please indicate relationship to patient for all family history conditions that apply)

Cataracts: Y N Glaucoma: Y N Macular Degeneration: Y N Retinal Detachment: Y N
Diabetes: Y N High Blood Pressure: Y N Other: _____

PATIENT'S SOCIAL HISTORY

Do you use tobacco products? Y N Do you drink alcohol more than 3 times per week? Y N Do you drive? Y N
Do you work on computers? Y N List your hobbies and sports:
_____

1. **RECEIPT OF NOTICE OF PRIVACY PRACTICES**
   I acknowledge that I have received North Shore Optometric Group's ***Notice of Privacy Practices***
2. **INSURANCE AUTHORIZATION AND PATIENT RESPONSIBILITY**
   I authorize the release of medical information necessary to process this claim, and assign medical benefits to myself or the named provider for professional services rendered. I further understand and agree that I am fully responsible for any balance for services rendered that my insurance does not cover.
3. **INSURANCE SIGNATURE ON FILE**
   If I am covered under Medicare or other insurance, this will serve as your file copy of my "Signature on File" for submitting Medicare and other insurance claims and accepting Medicare assignment on my behalf.

   Patient or aurthorized signature: _____ Date: _____

   Print Name: _____ Relationship to Patient: _____