218-18 Jamaica Avenue
Queens Village, NY 11428

PATIENT DEMOGRAPHICS

PATIENT NAME: _____ DATE: _____
Last First Middle

ADDRESS: _____
Street City State Zip Code

SS #: _____ DATE OF BIRTH: _____ SEX: ( ) MALE ( ) FEMALE MARRIAGE STATUS:_____

HOME PHONE #_____ CELL PHONE #_____

EMAIL: _____

RACE: ( ) Native American ( ) Asian ( ) African American ( ) Caucasian ( ) Other ( ) Decline

Ethnicity: ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Decline

OCCUPATION: _____ EMPLOYER'S NAME: _____

NAME, ADDRESS, TEL # OF PRIMARY CARE PHYSICIAN: _____

_____

WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____ PHONE: _____

RELATIONSHIP TO EMERGENCY CONTACT: _____

INSURANCE PRIMARY

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

INSURANCE SECONDARY

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

INSURANCE PAYMENT ORDER:

I authorize my insurance company to pay directly to Visionary Optometry, PLLC, all benefits due to me. This policy was in full force and effect at the time of treatment. I understand that I am financially responsible for all balances remaining after payment of possible insurance benefits and that, should it become necessary, any and all reasonable collection/attorney fees will be added to the patient's bill. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Visionary Optometry, PLLC, to furnish information to my insurance carriers and to other physicians who may become involved in my care, concerning illness and treatments received by me. I permit a copy of this authorization to be used in place of the original.

Legal Signature_____ Date_____

MEDICAL AND OCULAR HISTORY

DID YOU HAVE **OR** COME INTO CLOSE CONTACT WITH SOMEONE WITH SYMPTOMS OF COVID-19? ____ YES ____ NO
IF YES, PLEASE EXPLAIN SYMPTOMS: _____

CURRENT MEDICAL AND OCULAR CONDITIONS:

	YES	NO	Explain if Applicable:
HIGH BLOOD PRESSURE & HEART	w		
RESPIRATORY			
GASTROINTESTINAL			
GENITOURINARY			
SKIN, MUSCLES, BONES, JOINTS			
NEUROLOGICAL/ PSYCHIATRIC			
DIABETES			
THYROID			
HIGH RISK MEDICATIONS			CIRCLE IF APPLICABLE: (Plaquenil, Topamax, Epilepsy Medications, Amiodarone, Flomax, Tamoxifen, Prednisone, Interferon, Viagra)
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER?			TYPE:
HAVE YOU EVER HAD ANY EYE RELATED SURGERIES?			EXPLAIN:

WERE YOU DIAGNOSED WITH ANY EYE RELATED CONDITIONS SUCH AS GLAUCOMA, CATARACTS, MACULA DEGENERATION OR RETINAL DETACHMENT? ____ YES ____ NO

Please list other eye related conditions if applicable: _____

NAME of PREVIOUS EYE SPECIALIST _____

DO YOU WISH TO HAVE A DILATED EYE EXAMINATION PERFORMED TODAY? ____ YES ____ NO

CURRENT MEDICATIONS (list all prescribed and over-the-counter medications you are now taking and their dosages):

SURGICAL HISTORY: PLEASE LIST PREVIOUS SURGERIES

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____ YES ____ NO **LATEX ALLERGY?** __ YES __ NO
IF YES, PLEASE LIST MEDICATIONS:

FAMILY HISTORY

	YES	NO		YES	NO
HEART DISEASE or HIGH BLOOD PRESSURE			GLAUCOMA		
DIABETES			MACULA DEGENERATION		
ARTHRITIS			BLINDNESS		
CANCER			RETINAL CONDITIONS		
KIDNEY DISEASE			STRABISMUS (LAZY EYE)		
THYROID DISEASE					

SOCIAL HISTORY
DO YOU DRINK ALCOHOL? _____ YES ____ NO If YES: occasional 1/day 2-3/day 4+/day
DO YOU SMOKE? _____ YES ____ NO If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Signature_____ Date_____