NEW YORK CORNEA, PLLC

CORNEA AND EXTERNAL EYE DISEASE

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Demographic Information:

First Name: ______________________ Middle: ________ Last name: ______________________
Birth date: ______________ Sex: M____ F____ Social Security #: __________________________
Local Address: ___________________City:______________ State: ________ Zip:_______________
Secondary Address: (if applicable) ____
Home Phone #:___________________Work Phone#:___________________ Cell Phone #:_________________
Preferred method of contact: ______________________ Email: ____________________________________
May we leave a message: Yes___ No___ Occupation: _____________________________________
Referring Physician: _________________________________Referring Physician #: ______________________
Referring Physician Fax#: ________________________
Primary Care Physician: __________________________ Primary Care Physician Fax #:___________________
Emergency Contact: _________________________ Contact #:__________________________________
Marital Status: _______________________ Student Status: FT____ PT____

Federal Standards require us to collect the following:

Preferred Language______________________
Please Choose One Ethnicity: Hispanic/ Latino___ Non-Hispanic/Latino___ Unknown___ Patient Refused___
Please Choose One Race: Asian ___ Black: ____ African American___ Multiracial_____ Unknown____
White_____ Other_____ Patient Refused_____

Insurance Information

Name of Policy Holder: ________________________ Date of Birth: _____________________
Social Security________________________ Relationship to Patient: ________________________
Primary Insurance Carrier:______________________ ID#___________________________
Secondary Insurance Carrier::___________________ID#___________________________
Copayment Amount: __________

*** Please Note: We Are Not Responsible For Secondary Insurance Billing. We Only Accept The Automatic Crossovers From Medicare. ****

The Receptionist Will Need To Make Copies of Your Insurance Cards & Photo ID

Pharmacy Information:

Pharmacy Name: ____
Address: ____
City: ______________ State:____________ Zip:__________________________
Phone Number: _____________________ Fax Number: ____________________________

I verify the accuracy of the above information and I authorize the release of medical information necessary to process insurance claims and payment of services rendered. I also assume responsibility for services not covered under my medical insurance plan.

Signature: ____ Date:____________________________

Medical History Questionnaire

Name ______________________________ Date: ______________________________

Date of Birth ______________________________ Date of **last eye exam:** ______________________________

List any **medications** you currently take (prescription and over-the-counter)

____

____

Do you have any **allergies to medications**? ( ) YES ( ) NO

If YES, please list the medications:

____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, etc.) or **injuries**

____

____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.)

____

____

Pregnancy	**YES**	**NO**	
Is there any chance you may be pregnant?			
Are you currently breastfeeding?			

Do you ***currently*** have any of the following problems? If YES, please explain.

Symptoms	**YES**	**NO**	**EXPLANATION** (which eye, severity, duration)
EYES (glaucoma, cataract, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy/Gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess Tearing/Watering			
Glare/Light sensitivity			
Pain or soreness			
Infection (blepharitis)			
Tired eye(s)			
Crossed/Lazy eye(s)			
Drooping eyelid(s)			

General	YES	NO	EXPLANATION
Fever			
Weight Loss			
Fatigue			
High blood pressure			
Ear, Nose, Throat			
Cardiovascular			
Respiratory			
Kidney, Bladder, Genital			
Blood/Lymph			
Skin (acne, skin cancer, etc.)			
Gastrointestinal/Digestive System			
Musculoskeletal			
Endocrine/Reproductive			
Allergic/Immunologic (Sjogren's, etc)			
Psychiatric (depression, etc.)			
Neurological (multiple sclerosis, etc.)			
Family History	**YES**	**NO**	**Relationship to Patient** (circle)
			M = mother **F** = father **S** = sibling **GM** = grandmother **GF** = grandfather
Blindness			**M F S GM GF**
Glaucoma			**M F S GM GF**
Arthritis			**M F S GM GF**
Cancer			**M F S GM GF**
Diabetes			**M F S GM GF**
Heart Disease			**M F S GM GF**
Kidney Disease			**M F S GM GF**
Thyroid Disease			**M F S GM GF**
Lupus			**M F S GM GF**
Stroke			**M F S GM GF**
Other			
Social History	**YES**	**NO**	
Do you drive?			
Do you have visual difficulty when driving?			
Do you have problems with night vision?			
Do you currently wear glasses?			
If **yes**, how long have you had the current prescription?			
Do you currently wear contact lenses?			
If **yes**, how for how long?			
Have you ever tried contact lenses before?			
Do you drink alcohol?			
If **yes**, how often?			occasional 1 per day 2-3 per day 4+ per day
Do you smoke?			
If **yes**, how often?			occasional ½ pack/day 2-3 pack/day 4+pack/day
Have you ever had a blood transfusion?			

Patient Signature ______________________________ Date ____________________

Physician Signature ______________________________ Date ____________________