Neal S. Braff, O.D.

Welcome to our office! Please help us serve you best by giving us your information. Thank you!

Today's Date:_____ **Patient's Name**:_____ Birth Date: ___/___/___

Male / Female Married/Partner Single Separated Divorced Widow

Address:_____

Phone - Cell: (____)_____ Home: (____)_____ Work: (____)_____

Email:_____ Social Security Number:_____/_____/_____

Employer: _____ (Full Time / Part Time) Job Title: _____ Student

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PATIENT'S MEDICAL INFORMATION (Please circle all that apply)

Do you currently, or have you ever had any problems in the following areas:

Allergies Arthritis Cancer Cardiovascular Disorder Cholesterol Diabetes Endocrine

Gastrointestinal Headaches/Migraines Heart Disease High Blood Pressure Immune Disorder Kidney Disease

Lupus Musculoskeletal Neurological Disorder Pregnant Nursing Skin Disorder Thyroid Disease

Other:_____ **MEDICATIONS USED** (Please provide a complete list if possible)**:** _____

_____

_____ **Medication Allergies:** _____

Name of Primary Care Physician:_____ Phone #: (____)_____

PATIENT'S EYE HISTORY (Please circle all that apply)

LAST EYE EXAM:_____ **LAST CONTACT LENS EXAM/FITTING:** _____

Eye Surgery: (Year_____, Please describe_____) LASIK/PRK (Year:_____)

Eye Injuries: (Year_____ Please describe_____) Treated Eye Infection

Blindness Cataracts Crossed Eyes Drooping Eyelid Glaucoma Lazy Eye Macular Degeneration Retinal Disease

GLASSES: Distance Reading Multifocal Prescription Sunglasses **LAST GLASSES PURCHASE:** _____

Do you have the(se) glasses with you today? Yes / No

CONTACTS: RGP/Hard – (Single Vision / Bifocal) **Soft –** (Quarterly / Monthly / 2-Week / 1-Day) (Single Vision / Bi-focal /Mono-Vision)

Do you have these contact lenses with you today? Yes / No Which disinfection solution do you use? _____

Brand Name of your Contact Lenses (if known):_____ How old are the pair you are wearing? _____

Number of hours spent on the computer/day:_____ Number of hours spent on close-up work/day: _____

Do you drive a car? Yes / No Do you drive at night? Yes / No Do you have any difficulty seeing while driving? Yes / No

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REASON FOR YOUR VISIT TODAY (Please circle all that apply)

Annual/Routine Exam Annual/Eyeglass Prescription Annual/Contact Lens Fitting Medical Problem/Medical Follow-up

Problem w/Distance Vision Problem w/Near Vision Problem w/Computer Vision Dry Eyes Excessively Watery Eyes

Flashes Floaters Decreased Peripheral Vision Problem w/Glare or Light Sensitivity Problem w/ Night Driving

Interested in LASIK Vision Correction Other _____

FAMILY MEDICAL HISTORY

(Please circle any that apply to biological parents, grandparents, siblings or children; living or deceased)

Glaucoma **Macular Degeneration** **Cataract** **Retinal Detachment/Disease** **Crossed Eyes** **Blindness**

Diabetes **High Blood Pressure** **Heart Disease** **Kidney Disease** **Thyroid Disease** **Cancer** **Lupus**

Arthritis **Other:** _____

SOCIAL HISTORY

Do you drink alcohol? Yes / No Do you use tobacco products? Yes / No Do you use illegal drugs? Yes / No

GUARANTOR'S INFORMATION (Insurance Plan Member – Parent, Spouse, Guardian)

Name:_____ Birth Date:____/____/____ SS#:____/____/____

Address:_____

Phone: (____)_____ Email: _____

INSURANCE INFORMATION (Please list & provide cards to staff)

Medical Insurance Provider: _____ ID #: _____

Secondary Medical Provider: _____ ID#: _____

Vision Insurance Provider: _____ ID#: _____

Secondary Vision Provider: _____ ID#: _____

HOW DID YOU HEAR ABOUT US?

Vision Insurance Listing Medical Insurance Listing Internet Search (Yelp, Google, Demandforce, ZocDoc, Other)

Patient Referral:_____ Dr. Referral: _____

OUR COMMITMENT TO YOU

It is the policy of this office to keep your information confidential and require your permission to release information to another person. If you should need your medical records released, a form will need to be signed by you requesting that we do so. However, by signing below, you are giving us permission to release your information to the insurance carriers we bill or contact on your behalf and any doctor whom we refer you to, should it become necessary.

Our doctor and staff wish to provide you with the best possible care at all times, strive to answer all your questions to the best of our ability and hope you leave our office knowing we truly appreciate the choice you make to come to us for your eye care needs.

PATIENT RESPONSIBILITIES

I understand that I am responsible for providing the correct medical and/or vision insurance information for this date of service on or before the services are rendered and acknowledge that I will be responsible for any services not covered, for co-pays or co-insurance. I acknowledge that I have been made aware of the HIPPA notice of privacy practices, and that there are additional charges for contact lens services. I understand that you will bill the medical and/or vision plans for services and/or products provided by this office on my behalf whenever appropriate to do so. I understand that my bill today may not be the final amount because my insurance plan must be billed or due to changes that may occur to my material order(s) (such as a change in contact lens brand or type). I agree to pay an additional fee of $40 for the Optos Wide Angle Photograph for safely examining the back of the eyes.

Patient:_____ Date:_____

Guarantor: _____ Date: _____

Emergency Contact:_____ Relationship:_____ Phone #:_____