



The Optometrists

Helping you see your world

Dr. Ronald Henderson

Dr. Russell Brody

Patient Information: (Please Print)

(Please circle) Mr. Mrs. Ms. Miss Dr.

Name: _____ Date _____

Date of Birth _____ Age _____ M / F Soc Security # _____

Address _____
Street City State Zip

Phone: Home(_____) _____ Work (_____) _____

Email: _____

Occupation: _____ Employer _____

Complete if under 18 years or a student

Name of Father _____ Employer _____

Name of Mother _____ Employer _____

Address _____ Phone (_____) _____

Insurance Information

Subscriber's Name _____ Subscriber's Date of Birth ____/____/____

Patient's relation to Subscriber ___ Self ___ Spouse ___ Child ___ Other _____

Subscriber's SS# / ID Number _____

Subscriber's Employer _____

Vision Insurance: ___ VSP ___ Eyemed

Medical Insurance: ___ BCBS PPO ___ Humana PPO ___ Medicare

If you are a member of the above Insurance plans, your insurance company will be billed directly for services/ materials less any applicable deductions (Copays, Co-insurance, etc.). **Please provide your ID cards to the reception desk.** If you have other medical / vision insurance we will be happy to assist you in submitting a claim on your behalf for reimbursement to you.

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. **It is the responsibility of the patient (or parent if minor) to pay any deductible amount, co-insurance, or any balance not paid by your insurance**
2. Payment is expected at time of service, unless other arrangements have been made in advance. *In cases of Divorce, the parent/Guardian present with the child will be responsible for payment.*
3. In the event Dr. Henderson and Dr. Brody are not participating providers in your health plan you will be expected to pay for all services and materials received.
4. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services
5. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment

Privacy: I acknowledge that I received a copy of Dr's Ronald Henderson and Russell Brody Notice of Privacy Practices.

Signed (Patient or Parent if minor) _____ Date _____

_____ / _____ / _____
In compliance with Federal guidelines please fill out this form completely.

MEDICAL HISTORY

Are you presently taking any medications? Y N Please List _____
Do you have any allergies? Y N If yes, what? _____
Have you ever had eye surgery? Please list type, which eye and approximate dates
R _____ L _____
Do you have or have you ever worn eyeglasses? Y N If yes, how old is current prescription? _____
Do you wear or have you ever worn contact lenses? Y N If no, are you interested? Y N
If yes, how old is current prescription? _____ Are the contact lenses comfortable? Y N
Type of contact lenses: Rigid Soft Toric Monovision Bifocal Disposable Other _____
Do you work on a computer? Y N If yes, how many hours per day? _____
Date of last eye examination _____

FAMILY HISTORY

Does anyone in your family have or been treated for: (please circle)

Glaucoma	Retinal Problems	High blood pressure	Diabetes
Cataract	Thyroid Problems	Macular Degeneration	Turned or lazy eye

SOCIAL HISTORY *This information is kept strictly confidential*

Do you use tobacco products? Y N if yes, how long: _____
Do you drink alcohol? Y N if yes, how long: _____
Do you use illegal drugs? Y N if yes, how long: _____
Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYSTEMS Do you currently have or have you had any problem in the following areas?

CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT			
Fever, weight loss/gain	Y	N	?		Allergies/Hay Fever	Y	N	?
INTEGUMENTARY					Sinus congestion	Y	N	?
Skin condition	Y	N	?		Chronic Cough	Y	N	?
NEUROLOGICAL					RESPIRATORY			
Headaches/Migraines	Y	N	?		Asthma	Y	N	?
Seizures	Y	N	?		Chronic Bronchitis	Y	N	?
EYES					Emphysema	Y	N	?
Loss of vision	Y	N	?		VASCULAR/CARDIOVASCULAR			
Blurred Vision	Y	N	?		Diabetes	Y	N	?
Distorted Vision/Halos	Y	N	?		High Blood Pressure	Y	N	?
Double Vision	Y	N	?		GASTROINTESTINAL			
Dryness	Y	N	?		Diarrhea/Constipation	Y	N	?
Mucous Discharge	Y	N	?		GENITOURINARY			
Redness	Y	N	?		Genitals/Kidney/Bladder	Y	N	?
Itching	Y	N	?		BONES/JOINT/MUSCLES			
Burning	Y	N	?		Rheumatoid Arthritis	Y	N	?
Foreign Body Sensation	Y	N	?		Muscle/Joint Pain	Y	N	?
Tearing/Watering	Y	N	?		LYMPHATIC/HEMATOLOGIC			
Glare or Light Sensitivity	Y	N	?		Anemia	Y	N	?
Flashes/Floaters	Y	N	?		Bleeding Problems	Y	N	?
ENDOCRINE					ALLERGIC/IMMUNOLOGIC	Y	N	?
Thyroid/ Other Glands	Y	N	?		PSYCHIATRIC	Y	N	?