Valley Stream Optometric Services

10 East Merrick Road Suite 201
Valley Stream, NY 11580
516-825-7455

A MEMBER OF VISION SOURCE

□Dr. □ Mr. □ Mrs. □ Male □Single □Divorced
□Ms. □Miss □ Female □Married □Widowed **Date of Birth** _____/_____/_____

Last Name_____ **First Name**_____MI_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home # (_____)_____ **Work #** (_____)_____ **Mobile #** (_____)_____ □ Do not text

Employer_____ Occupation_____ **Prefered communication:**□Email □Phone □Postal

SSN_____-_____-_____ **How were your referred to our office**?_____

Pref Lang.: □Eng □Other_____ **Race**: □White □AA □Hisp. □Asian □Native Am. □Other_____ **Ethnicity**: □Non-Hisp. □Hispanic

E-MAIL: You will receive appointment reminders, order notifications, yearly recalls, eye care news, and special promotions. You may opt out at any time.

Vision Insurance: □ None □VSP □Spectera □Davis □March □ EyeMed □Other_____

Medical Insurance: □Blue Cross / Shield □ HIP/GHI □ UHC □Cigna □Aetna □Medicare □ Oxford □Other_____

Member_____ **Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

Member_____ **Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

FAMILY MEMBERS

Name	Relation	DOB	Current patient at our office?
1. _____	_____	_____	YES / NO
2. _____	_____	_____	YES / NO
3. _____	_____	_____	YES / NO

Refraction Policy A refraction determines the lens prescription you will need for glasses or contacts. It is also a necessary part of the cataract evaluation. It is separate from the MEDICAL portion of your exam. Unfortunately, the refraction is a NON-COVERED service by Medicare and most medical insurance plans. They consider refractions a "VISION" service and not a "MEDICAL" service. Separate VISION plans pay for refraction. Without a refraction you cannot get an updated glasses prescription. The $40 refraction fee is collected a time of service.

Payments and Co-Payments All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts VISA, Master Card, debit cards and personal checks with proper identification. All personal checks returned for any reason are subject to a $25 service charge without exception. In the event of nonpayment, the cost of collection and or court costs and reasonable legal fees is the responsibility of the patient.

Vision Plan and Insurance Benefits It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of Valley Stream Optometry will, to the best of their knowledge and understanding, help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

Assignment of Benefits I authorize assignment of vision plan and insurance benefits to Valley Stream Optometry for the purpose of determining eligibility, benefits, and collecting for all services rendered and materials provided. In addition, I authorize Valley Stream Optometry and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary.

Misses, Broken & Cancelled Appointments If a scheduled appointment time is missed, broken, or cancelled for any reason without 48 hours notice, a fee of $50 may be assessed to your account. Please notify the office at least 48 hours in advance if you are unable to keep your appointment.

HIPPA Compliancy I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) for this office. I have read and understood the terms and conditions outlined above, and I hereby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

Signature:_____ **Date:**_____

Primary Care Physician (or name of Clinic)_____**Dr.'s Phone #** (____)_____

Please complete the following Medical History for yourself and your family as thoroughly as possible. Many medical conditions may involve the eyes even though it may seem unlikely. Many medications can also have effects on your eyes so please list any and all medications you are currently taking.

Are you pregnant and / or Nursing? □No □Yes…If yes, how many weeks / months along are you?_____

Date of last Physical:_____ **Date of last Eye Exam (here or elsewhere)**_____

HEALTH HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Integumentary (Skin)	□	□	_____	High Blood Pressure	□	□	_____
Headaches	□	□	_____	Heart Disease	□	□	_____
Migrianes	□	□	_____	Elevated Cholesterol	□	□	_____
Ears, Nose, Mouth, Throat	□	□	_____	Gastrointestinal	□	□	_____
Arthritis	□	□	_____	Kidney Disease	□	□	_____
Asthma / Lung Disease	□	□	_____	Lupus	□	□	_____
Cancer	□	□	_____	Thyroid Disorder	□	□	_____
Diabetes Type I	□	□	_____	Psychiatric	□	□	_____
Diabetes Type II	□	□	_____	Other	□	□	_____

OCULAR HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Glaucoma	□	□	_____	Eye Infections	□	□	_____
Macular Degeneration	□	□	_____	Blindness	□	□	_____
Cataracts	□	□	_____	Crossed Eyes	□	□	_____
Retinal	□	□	_____	Lazy Eyes	□	□	_____
Optic Nerve Disease	□	□	_____	Drooping Eyelid	□	□	_____
Eye Injury	□	□	_____	Other	□	□	_____

Medication Allergies: □None □Penicillin □Sulfa drugs □Other_____

List any Medications you Currently take (including oral contraceptives, OTC medications, aspirin, and home remedies) □None

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all major injuries, surgeries, hospitalizations you have had (approx date) *including* EYE injuries / surgery: LASIK/PRK, Cataract etc.

□None _____

SOCIAL HISTORY

Please list hobbies you enjoy

_____

Do you drink alcohol? □No □Yes How often? □Social use □1-2 drink daily □Dependent □Other _____

Do you use tobacco product? □No □Former user □Yes How often? □Less than 1pk day □1-2pk day □More than 2pk / day

Do you use recreational drugs? □No □Recreational use □Chemical dependence Type:_____

Have you ever been exposed to or infected with ?

STD's □No □Yes _____ Blood Transfusion □No □Yes

Do you wear glasses? □No □Yes If yes, how old are your current pairs of glasses? _____

Do you wear contact lenses? □No □Yes Type of lens: □Soft □Toric (for astigmatism) □Gas Permeable (hard) □Multifocal / Monovision

How often do you replace your lenses? □Daily □2 weeks □Monthly □Annual □Other_____

Do you sleep in your lenses? □No □Yes **What is the brand of contact lens worn?**_____

What solution do you use? □Optifree Replenish / Pure Moist □BioTrue □Renu □Other_____

Reason for your visit today?

□Check eye health	□Distance Blur	□Near Blur	□Computer Blur / Fatigue	□Night vision blur
□Headaches	□Eyestrain	□Burning	□Watering	□Itching
□Pressure around eyes	□Dry / Sandy / Gritty feeling	□Tired eyes	□Computer Vision fatigue	□Eye pain
□Red eyes	□Flashes / Floaters	□Double vision	□Loss of side vision	□Light sensitivity

□Other (describe)_____