Southern Dutchess EYE CARE
discover the clear difference

969 Main Street, Ste H
Fishkill, New York 12524
ph: (845) 896-6700
www.sdec2020.com

Welcome back to our office. Please provide us with an update of your current health information.

Patient Name_____ Email Address_____

* Your email address may be used to communicate special eye care offers, practice news or information useful to you. It will not be sold or released to third parties.

Current Medications: _____

_____

Current Eyedrops: _____

_____

Medicines That Cause Reactions or Sensitivities: _____

Specific Allergies: _____

GENERAL HEALTH CONDITION

Fever [OYes ONo] Respiratory (Asthma) [OYes ONo] Anxiety or Depression [OYes ONo]
Weight Loss [OYes ONo] Gastrointestinal [OYes ONo] Endocrine (Thyroid, Diabetes)[OYes ONo]
Other Symptoms [OYes ONo] Kidney [OYes ONo] Blood / Lymph [OYes ONo]
Ears, Nose, Throat [OYes ONo] Muscles, Bones, Joints [OYes ONo] Allergic [OYes ONo]
Cardiovascular (High [OYes ONo] Skin [OYes ONo] Are You ? OPregnant
Blood Pressure, etc.) Neurological (Multiple Sclerosis) [OYes ONo] ONursing

FAMILY HISTORY

Amblyopia (Lazy Eye) [OYes ONo] Retinal Detachment [OYes ONo] High Blood Pressure [OYes ONo]
Blindness [OYes ONo] Strabismus (Eye Turn) [OYes ONo] Kidney Disease [OYes ONo]
Cataract(s) [OYes ONo] Arthritis [OYes ONo] Lupus [OYes ONo]
Color Blindness [OYes ONo] Cancer [OYes ONo] Stroke [OYes ONo]
Glaucoma [OYes ONo] Diabetes [OYes ONo] Thyroid Disease [OYes ONo]
Macular Degeneration [OYes ONo] Heart Disease [OYes ONo] Others [OYes ONo]

SOCIAL HISTORY

Do you use nutritional supplements (Vitamins, etc.)? O Yes O No
Do you engage in regular exercise? O Yes O No
Do you drink alcohol? If yes, how often?: O No O Occasional O 1 per day O 2-3/day O 4+/day
Do you smoke? If yes how often?: O No O Occasional O 1/2 pack per day O 1+ pack
Method of tobacco intake: O Smoking O Chewing
Do you use illegal drugs?: O Yes O No
Hobbies/ Interests: _____

Please Read:
I request that payment of authorized insurance benefits (including Medicare benefits) for any services furnished me, be made on my behalf to Brian D. Peralta OD., Brian Powell O.D., and/or Gary M. Weiner O.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
I acknowledge that I have received a copy of the Southern Dutchess Eye Care Notice of Privacy Practices.
For Medicare Patients:
I have been notified by my physician that Medicare is likely to deny payment for the services identified below for the reasons stated. I agree to be personally and fully responsible for payment if Medicare denies payment. I understand that, by law, the physician is obliged to bill me for uncovered services. (Medicare pays 80% of **covered** services after your deductible is met.) **Medicare does not pay for the refraction portion of an eye examination. Medicare does not pay for frames or lenses unless the patient has undergone cataract-removal surgery. Routine eye exams are not covered.**

_____ _____
Signature Date