Southern Dutchess
EYE CARE
discover the clear difference

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Welcome to Southern Dutchess Eye Care LLP. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address* _____ Spouse or Parent(s) Name _____ Person Responsible for Account _____

* 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.

Emergency Contact _____ Emergency Phone _____

How were you referred to our o ce?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name)
☐ Insurance Listing ☐ Drive By ☐ Other _____ ☐ Doctor (Please Name)

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

☐ M ☐ F Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full-Time Student ☐ Part-Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company _____ City _____ State _____ Zip _____

☐ M ☐ F Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

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 O.D., 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 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 _____

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____ Phone _____

Address of Primary Care Physician _____ City _____ State _____ Zip _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____ Phone _____

Address of Referring Physician _____ City _____ State _____ Zip _____

HEALTH HISTORY

What is the main reason for today's exam? _____ When was your last exam? _____ When was your last health exam? _____

Past illnesses or injuries: _____

Past Surgeries: _____

Current Medications: _____

_____

Current Eyedrops: _____

Medicines that cause reactions or sensitivites: _____

Specific Allergies: _____

EYE HISTORY

☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Dryness	☐ Yes	☐ No	Strabismus *(Crossed Eyes)*
☐ Yes	☐ No	Cataract	☐ Yes	☐ No	Excess Tearing/Watering	☐ Yes	☐ No	Blurred Vision Distance
☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No	Blurred Vision Near
☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No	Foreign Body Sensation	☐ Yes	☐ No	Distorted Vision *(Halos)*
☐ Yes	☐ No	Color Blindness	☐ Yes	☐ No	Infection of Eye or Lid	☐ Yes	☐ No	Double Vision
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Itching	☐ Yes	☐ No	Floaters or Spots
☐ Yes	☐ No	Glare/Light Sensitivity	☐ Yes	☐ No	Mucous Discharge	☐ Yes	☐ No	Fluctuating Vision
☐ Yes	☐ No	Tired Eyes	☐ Yes	☐ No	Drooping Eyelid	☐ Yes	☐ No	Loss of Vision
☐ Yes	☐ No	Amblyopia *(Lazy Eye)*	☐ Yes	☐ No	Redness	☐ Yes	☐ No	Loss of Side Vision
☐ Yes	☐ No	Burning	☐ Yes	☐ No	Sandy or Gritty Feeling			

GENERAL HEALTH CONDITION

☐ Yes	☐ No	Fever	☐ Yes	☐ No	Respiratory *(Asthma)*	☐ Yes	☐ No	Anxiety or Depression
☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No	Gastrointestinal	☐ Yes	☐ No	Endocrine (Thyroid, Diabetes)
☐ Yes	☐ No	Other Symptoms	☐ Yes	☐ No	Kidney	☐ Yes	☐ No	Blood/Lymph
☐ Yes	☐ No	Ears, Nose, Throat	☐ Yes	☐ No	Muscles, Bones, Joints	☐ Yes	☐ No	Allergic
☐ Yes	☐ No	Cardiovascular *(High Blood Pressure, etc.)*	☐ Yes	☐ No	Skin	☐ Yes	☐ No	Are You Pregnant?
			☐ Yes	☐ No	Neurological (Multiple Sclerosis)	☐ Yes	☐ No	Nursing?

FAMILY HISTORY

☐ Yes	☐ No	Amblyopia *(Lazy Eye)*	☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No	High Blood Pressure
☐ Yes	☐ No	Blindness	☐ Yes	☐ No	Strabismus *(Eye Turn)*	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Cataract(s)	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Color Blindness	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Thyroid Disease
☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Others

MEDICAL HISTORY QUESTIONNAIRE

SOCIAL HISTORY

_____ _____ _____
Current Occupation Years Employer

SPECTACLE LENS HISTORY

Do you use a computer? ☐ Yes ☐ No How many hours/day? _____ Distance from Computer: _____

Do you drive? ☐ Yes ☐ No Mileage to work each way? _____ Do you have glare problems? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No Do you have problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since: _____

Type of glasses
☐ Full-time ☐ Part-time ☐ Distance ☐ Close

Glasses Owned
☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Back-Up Glasses
☐ Safety Glasses ☐ Sports Glasses ☐ Progressive

Have you had trouble in the past with glasses? ☐ Yes ☐ No _____

Do you wear sunglasses? ☐ Yes ☐ No Are your sunglasses your current prescription? ☐ Yes ☐ No

SPECIAL EYEWEAR NEEDS
☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY
Have you ever tried to wear contact lenses? ☐ Yes ☐ No Reason for stopping? _____

Do you currently wear contact lenses? ☐ Yes ☐ No Since: _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Type and brand of contact lenses? _____ Today's wearing time? _____

How many hours per day? _____ How many days per week? _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT.

Lens Comfort R:_____ L:_____ Distance Vision R:_____ L:_____ Near Vision R:_____ L:_____

What solutions do you use? Cleaner: _____ Disinfectant: _____ Enzyme: _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc?) ☐ Yes ☐ No Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol? If yes, how much/often? ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Do you smoke? If yes, how much/often? ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Method of tobacco intake: ☐ Smoking ☐ Chewing Do you use illegal drugs? ☐ Yes ☐ No

Hobbies / Interests: _____