WELCOME TO KATONAH EYECARE

Please fax forms back to **914-232-9599***. Thank You*

1. PATIENT INFORMATION

(Please Print)

Today's Date______________

Patient Name____

Address____

City____ State______ ZIP________________

Sex M____ F____ Age_________ Birthdate____

Single______ Married______ Widowed______ Separated______ Divorced______

Patient SS#____

Occupation____

Spouse's Name____Birthdate______________________

Whom may we thank for referring you?____

How did you hear about us?____

2. PHONE NUMBERS

Home_________________________ Work ________________________Mobile______________________

Email Address____

Spouse's Phone____

Best time and place to reach you____

IN CASE OF EMERGENCY (Specifically someone who does not live in your household.)

Name___________________________________ Relationship_______________________________________

Home Phone__________________________________ Work Phone__________________________________

3. CHIEF COMPLAINT

Please list the main reasons for your appointment today____

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4. EYE HEALTH HISTORY

Previous Eye Doctor____

Date of last exam?____

Do you wear glasses? Yes____ No____

All the Time_________ Occasionally_________ Reading_________ Driving_________ TV_________

Do you wear contacts? Yes____ No____

Type____ Hours/Day___________________

Please describe any injury, surgery, or trauma you have had to your eyes?___________________________

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5. HEALTH HISTORY

Primary Care Physician's Name:_________________________________ Phone:____________________

Please describe any history or current health problems_____________________________________

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6. MEDICATIONS

List medications you are currently taking, including eyedrops:

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7. ALLERGIES

List your allergies to medications or other substances:

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8. HOBBIES

Please list any eye related sports or hobby activity:

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9. INSURANCE

Who is responsible for this account?____

Relationship to Patient____

Insurance Co.____

Group #____

Is patient covered by additional insurance? Yes____ No____

Subscriber Name____

Birthdate ____ SS#_______________________________

Relationship to Patient____

Insurance Co.____

Group #____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________

_____________________ and assign directly to Dr. Stephen Gordon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature____

Relationship____ Date__________________________

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