YARDLEY EYE CARE

Dr. Brian M. Cohen, Optometrist

ADULT PATIENT REGISTRATION & MEDICAL HISTORY

We require payment in full/or insurance co-pays at the time services are rendered or eyewear is ordered. We accept cash, check, Visa, MasterCard, and Discover credit cards and Care Credit financing.

Date_____ Birth date_____/_____/_____ Email address_____

How did you learn about us? ❑ Friend ❑ Family ❑ Insurance ❑ Internet/Website ❑ Other_____

Last Name_____ First Name_____ M.I.____ ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Rev

Street_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Preferred contact method: ❑ home ❑ cell

Sex: ❑ M ❑ F Social Security #_____-_____-_____ Employer_____ Work Phone_____

Emergency Contact Person-Name & Phone #_____

Marital Status_____ Spouse's name & Employer_____

Insurance Information

Do you have vision insurance? ❑ Yes ❑ No Do you have health insurance? ❑ Yes ❑ No

Name of insurance company_____

Policy Holder's Name: Last_____ First_____ M.I._____

Policy Holder's Social Security #_____-_____-_____ Policy Holder's Birth Date _____/_____/_____

Please bring both your vision and health insurance cards to your appointment.
Co-pays & deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment.

(Please give your insurance cards to the office staff)

Who is your family physician?_____ City/Loc._____

List any medication or eye drops you are allergic to: _____

List any medication you are taking now - *Prescription or Over the Counter* _____

_____

Please check your answers to all the questions below.

Your General Health	**Family Health History**	**Vision Needs**	**Options**
Have you ever had or do you currently have…	Has anyone in your family had….	Do you do any of the following?	Do any of the following options appeal to you?
❑ Allergies	❑ Diabetes	❑ Crafts/Sew	❑ Thinner/Lightweight Lenses
❑ Arthritis	❑ Glaucoma	❑ Gardening	❑ Lenses that Darken
❑ Diabetes	❑ Blindness	❑ Computer	❑ No-Line BiFocals
❑ Cancer	❑ Cataracts	❑ Read Books	❑ Anti-Glare Treatment
❑ Headaches	❑ Crossed Eyes	❑ Golf	❑ Contact Lenses
❑ Gastrointestinal Disease	❑ Lazy Eye	❑ Team Sports	❑ Laser Vision Correction
❑ Drug Reaction	❑ Macular Degeneration	❑ Music	❑ Scratch Resistant Coating
❑ Heart Disease	❑ None of the above	❑ Shooting	❑ Sunglasses/Sun Clip
❑ High Blood Pressure		❑ Racquet Sports	❑ Safety Glasses
❑ Thyroid Disease	**SOCIAL HISTORY**	❑ Skiing	❑ Computer Glasses
❑ Kidney Disease	Do you……	❑ Fishing	❑ Golfing/biking/fishing Rx
❑ Respiratory Disease	❑ Smoke	❑ Woodshop	❑ Sports Glasses
❑ Eye Disease	❑ Consume Alcohol	❑ Water Sports	❑ TV glasses
❑ Eye Surgery	❑ Use Street Drugs	❑ None of the Above	
❑ Other _____	❑ None of the Above		
❑ None of the above			

I Authorize the release of medical and other necessary information to process insurance Claims,and where applicable, also request payment of government benefits to the party who accepts assignment. Signature authorizes the payment of medical benefits to the physician or supplier for services rendered.

Patient Signature_____ Date_____