Name Mrs. Ms. Mr. Dr. _____ (circle)Male/Female Today's date_____

Street _____ City _____ Zip _____

Home Phone # (____)_____ Work Phone#(____)_____ Cell Phone#(____)_____

Date of birth _____/_____/_____ Social Security# _____-____-_____ Occupation _____

Email_____How were you referred?_____

Date of last eye examination: _____ Doctor _____

Date of last physical exam : _____ Primary Care Doctor _____
PCP Phone # _____

What is the main reason for today's visit?

_____

_____

Medical History

Do you or anyone in your family have (had) any of the following conditions?

	Yes	No	If a relative, indicate their relationship to you.
Glaucoma			
High blood Pressure			
Diabetes			
Heart Disease			
Allergies			
Headaches			
Asthma			
Arthritis			
Skin Disorders			
Other Diseases			If yes, please list.
Take Medications?			If yes, please list.

((Please turn over))

Eye History

	Yes	No	If yes, for how long?
Blurred distance vision (far vision)			
Blurred reading vision (near vision)			
Discharge from eyes			
Red Eyes			
Itching			
Sandy feeling/Grittiness			
Burning			
Tearing/Wetness			
Eyes feel tired			
Sensitivity to light			
Eye pain			
Spots or floating objects in vision			
Flashing lights			
Double vision			

Have you ever needed or received (if so, indicate when and describe.)

Eye surgery _____

Eye medication _____

Eye injury _____

Do you use a computer?

Yes No **How many hours per day?** _____

Have any questions about anything from the following list? (Please circle)

-Hard contact Lenses -Gas Permeable Lenses -Aphakic (cataract) eyewear
-Progressive bifocals -Soft Contact Lenses -Bifocal Contact Lenses
-Sports Eyewear -Extended Wear lenses -Disposable Lenses
-Occupational Eyewear -Prescription Outdoor Sunglasses

Medical Insurance Information:

Do you have vision coverage? Yes / No **What company?** _____

Do you have medical insurance? Yes / No **What company?** _____

Policy Holder's name _____ **Member's ID#**____ _____

Member's Group# _____

Malik
Eye Care

205-04 Hillside Ave
Hollis, NY 11423
Ph. 718-464-2020

90-14 Elmhurst Ave
Jackson Heights, NY 11372
Ph. 718-651-2200

PATIENT RESPONSIBILITY FORM AND SIGNATURE ON FILE FORM

I authorize the release of any medical or other information necessary to process any claims. I request payment of Government benefits either to myself or to the party that accepts assignment. I also authorize payment of medical benefits to the physician or supplier for services rendered.
I am aware that I am responsible for any balance that my health insurance policy does not cover; this is also including any deductible or co-payment that is applied to my account since I am attending to participating provider.

FIRMA DE RESPONSABILIDAD & DE HISTORIA MEDICA DEL PACIENTE.

Por medio de la presente yo autorizo la liberacion de mi historial medico o cualquier informacion necesaria con el proposito de procesar las cuentas de mis atenciones medicas. Tambien autorizo el pago de los beneficios medicos de mi seguro al medico o centro medico que me hayan prestado atencion medica.

Estoy conciente de que soy responsible por cualquier cuenta que mi seguro medico no cobra, esto incluye cualquier deducible, co-pago o servicios que mi cobertura no pague por cualquier razon o motivo a pesar de yo tener seguro medico.

_____ _____

Patient signature on file/Firma del paciente Date/Fecha