eyemagination OPTICAL

David Galina O.D.

1581 Route 202 Suite 19 ~ Pomona, NY 10901 ~ 845-354-5661

Date: ____/____/____

PATIENT INFORMATION

Full Name: _____ ☐ Male ☐ Female

Address: _____ Home Phone: _____ Cell Phone: _____

City / State / Zip: _____ Work Phone: _____

Birth Date: ____/____/____ Email: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Date of last eye exam: ____/____/____

Occupation: _____ Referred by: _____

INSURANCE INFORMATION

VISION Plan Name: _____ ID#/Group#: _____

Full Name of Insured: _____ Insured's DOB: ____/____/____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

MEDICAL Plan Name: _____ ID#/Group#: _____

Full Name of Insured: _____ Insured's DOB: ____/____/____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PHARMACY Name: _____ City, State & Phone: _____

MEDICAL INFORMATION

MEDICAL HISTORY:

Select any of the following medical conditions that you currently have: NONE: ☐

☐ Anxiety	☐ Colon Cancer	☐ Hearing Loss	☐ Leukemia
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Lung Cancer
☐ Asthma	☐ Coronary Artery Disease	☐ Hypertension	☐ Lymphoma
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Depression	☐ HIV / AIDS	☐ Prostate Cancer
☐ Bone Marrow Transplant	☐ Diabetes	☐ Hypercholesterolemia	☐ Radiation Treatment
☐ BPH	☐ End Stage Renal Disease	☐ Hyperthyroidism	☐ Seizures
☐ Breast Cancer	☐ GERD	☐ Hypothyroidism	☐ Stroke
☐ Other: _____			

PAST SURGERIES:

Have you had any surgeries on the following organs: NONE: ☐

☐ Appendix	☐ Ovaries _____
☐ Bladder	☐ Pancreas _____
☐ Breast _____	☐ Prostate _____
☐ Colon _____	☐ Rectum _____
☐ Gallbladder	☐ Skin _____
☐ Heart _____	☐ Spleen
☐ Joint Replacement ☐ Hip ☐ Knee	☐ Testicles
☐ Kidney _____	☐ Uterus _____
☐ Liver	
☐ Other: _____	

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MEDICAL INFORMATION CONTINUED

OCULAR HISTORY:

Select any of the following that apply and circle Right or Left eye: NONE: ☐

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract: Right / Left
- ☐ Contact Lenses
- ☐ Corneal Dystrophy: Right / Left
- ☐ Diabetic Retinopathy Background: Right / Left
- ☐ Diabetic Retinopathy Proliferative: Right / Left
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma: Right / Left
- ☐ Macular Degeneration: Right / Left
- ☐ Macular ERM: Right / Left
- ☐ Narrow Angles: Right / Left
- ☐ Ocular Hypertension: Right / Left
- ☐ Ophthalmic Migraine: Right / Left
- ☐ Pseudoexfoliation
- ☐ Retinal Tear: Right / Left
- ☐ Stabismus
- ☐ PVD OD: Right / Left
- ☐ Vitreous Floaters: Right / Left
- ☐ Other: _____

OCULAR SURGERY:

Select any of the following that apply and circle Right or Left eye: NONE: ☐

- ☐ Blepharoplasty: Right / Left
- ☐ Cataract Surgery: Right / Left
- ☐ Corneal Transplant: Right / Left
- ☐ DSAEL: Right / Left
- ☐ Eye Muscle Surgers
- ☐ Intravitreal Injections: Right / Left
- ☐ LASIK: Right / Left
- ☐ LPI: Right / Left
- ☐ LPT: Right / Left
- ☐ PRK: Right / Left
- ☐ Ptosis Repair: Right / Left
- ☐ Punctual Plugs: Right / Left
- ☐ Strabismus Surgery: Right / Left
- ☐ Retinal Laser: Right / Left
- ☐ Trabeculectomy: Right / Left
- ☐ Tube Shunt: Right / Left
- ☐ Yag Capsulotomy: Right / Left
- ☐ Other: _____

MEDICATIONS AND ALLERGIES

Name of family doctor (PCP): _____

Current medication(s)-List: Check if none: ☐

1) _____
2) _____
3) _____
4) _____
5) _____

Allergies to medication? ☐ Yes ☐ No Which? _____ Reactions? _____

What is your general health? _____

FAMILY HISTORY

High Blood pressure	☐ Yes	☐ No	Relation _____	Retinal detachment	☐ Yes	☐ No	Relation _____
Diabetes	☐ Yes	☐ No	Relation _____	Cataracts	☐ Yes	☐ No	Relation _____
Glaucoma	☐ Yes	☐ No	Relation _____	Melanoma	☐ Yes	☐ No	Relation _____
Macular degeneration	☐ Yes	☐ No	Relation _____	Other: _____			

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PRIVACY INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

What is the preferred method to reach you? ☐ Home ☐ Work ☐ Cell ☐ Email

Approval to leave a message on/with:

Answering machine?	☐ Yes	☐ No	Send through the mail?	☐ Yes	☐ No
Office Voice mail?	☐ Yes	☐ No	Send via email?	☐ Yes	☐ No
With another person?	☐ Yes	☐ No	Cell phone?	☐ Yes	☐ No

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additional HIPAA Contact Instructions: _____

- I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE PATIENT.
- I AUTHORIZE RELEASE OF ALL MEDICAL/OPTICAL RECORDS, COPIES OF THIS AUTHORIZATION, AND ANY INFORMATION NECESSARY FOR MY TREATMENT OR CLAIM TO MY CARE PROVIDERS, BILLING AGENTS AND INSURANCE CARRIERS AS NEEDED.
- I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO EYEMAGINATION FOR INSURANCE IN WHICH EYEMAGINATION PARTICIPATES.
- A COPY OF THE HIPPA PRIVACY RULES AND REGULATIONS HAS BEEN MADE AVAILABLE TO ME.
- I UNDERSTAND PAYMENT OF CHARGES IS DUE AT THE TIME OF SERVICE, UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE PRIOR TO TREATMENT, AND I ACCEPT FULL FINANCIAL RESPONSIBILITY, INCLUDING CHARGES NOT COVERED BY MY INSURANCE AND AGREE TO PAY 1% INTEREST/MONTH ON THE UNPAID BALANCE AS WELL AS ATTORNEY AND COLLECTION FEES REQUIRED TO COLLECT AMOUNTS.
- I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, RELEASE OF MEDICAL/OPTICAL INFORMATION, INSURANCE AUTHORIZATION AND MY FINANCIAL RESPONSIBILITY.

SIGNED: _____ DATE: _____