Welcome to West Village Eyecare

Personal Information:

Name: _____ Preferred Name: _____

Address: _____ Apt No.: _____

City / State / Zip Code: _____

Email Address: _____

Home Telephone: _____ Mobile Telephone: _____

DOB: _____ Age: _____ Social Security No. _____

Sex: M F Marital Status: Single Married/Domestic Partner Divorced Widowed

Parent or Spouse's Name: _____

Additional Contact Information:

General Physician's Name: _____ Telephone #: _____

Referred By: _____ Telephone #: _____

Emergency Contact : _____ Telephone #: _____

Insurance and Payment:

Preferred Method of Payment: Cash Visa / MasterCard Amex

INSURANCE COVERAGE: We are a provider for a number of managed vision care plans. If you have one of these plans, we will gladly accept assignment. If you do not, we will gladly fill out any forms you would need for reimbursement.

Vision Care Insurance Plan: _____ ID: _____

Patient's Relationship to Insured: Self Spouse / Significant Other Child

Health Insurance Plan: _____ ID: _____

Patient's Relationship to Insured: Self Spouse / Significant Other Child

PLEASE READ, SIGN AND DATE

FOR PATIENTS WITH MANAGED CARE OR VOUCHER PLANS: I hereby assign my insurance benefit to be paid directly to West Village Eyecare. I understand that I will be responsible for any deductibles or co-payments. If my insurance coverage is denied, I will be responsible for all usual and customary fees. I understand that my vision plan my not cover all examinations, tests, and treatments that West Village Eyecare deem necessary or advisable.

If I decline these items or choose to go elsewhere through other coverage, I will not hold West Village Eyecare liable for any damages due to my delay in seeking treatment.

FOR ALL PATIENTS: If my account must be turned over for collection, I will also be responsible for all interest and collection fees.

Signature: _____ Date: _____

Health Information:

Many disease of the body have serious health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is important that we acquire an in-depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them. This information is also critical in the event we need to prescribe certain medications.

Date of last exam: How old are your glasses? Do you wear contacts lens?

Do you work on a computer? Approximately how many hours per day:

Personal Eye History (check all that apply):

Previous Eye Injury	Dry Eyes	Retinal Detachment
Previous Eye Surgery	Cataracts	Floaters
Glaucoma	Macular Degeneration	

Family Eye / Medical History (check all that apply):

Glaucoma:	Family Member: _____
Cataracts:	Family Member: _____
Retinal Detachment:	Family Member: _____
Eye Muscle Imbalance:	Family Member: _____

Personal Medical History:

1) Are you presently under the care of a physician?

If yes, for what reason(s)? _____

2) Are you taking any medications now?

If yes, please list all medications: _____

Women: Are you taking birth control pills?

3) Are you taking any medications that do not need a prescription?

If yes, please list all medications: _____

4) Are you allergic to: Antibiotics Local anesthetics Sulfa Drugs Penicillin

Are you allergic to any other medications? Please list them _____

5) Do you smoke cigarettes? How many per day?

6) Do you consume alcohol on a daily basis?

7) Is your blood pressure: Normal High Low

8) Women: Are you pregnant? How long have you been pregnant? _____

Do you have, or have you ever been informed that you had any of the following (check all that apply):

Chest Pains	Diabetes	Asthma or Hay Fever
Heart Disease	Epilepsy or Seizures	Sinus Trouble
Headaches	High Cholesterol	Arthritis
Lung Problems	Persistent Cough	AIDS
Hypertension	Skin Disease	Enlarged Lymph Nodes
Stroke	Migraines	Excessive Urination
Allergies or Hives	Cancer or Leukemia	Multiple Sclerosis
HIV Disease	Sickle Cell Disease	Sexually Transmitted Disease (Gonorrhea, Syphilis, Genital Herpes)
Thyroid Issues	Sarcoidosis	
Hormonal Issues	Lupus	
Tuberculosis	Lyme Disease	Repeated Cold Sores or Cancer Sores

COVID-19:

For your safety, the safety of the staff and future patients, please answer the following questions:

1) Have you or someone in close proximity to you had a fever within the last 14 days?

2) In the last 14 days, have you been in close contact with a confirmed or possible COVID-19 person?

3) Have you traveled in the last 14 days?

If yes, where? _____

4) Have you experienced any cold or flu like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, or difficultly breathing?

Vaccination:

1) Have you been vaccinated? Yes No

2) If so, which vaccination did you receive: Johnson & Johnson, Pfizer, Moderna, or other _____

3) Depending on the vaccine brand, did you complete your required second shot? Yes No

4) When did you complete your final dosing? _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

The *Notice of Privacy Practices* is attached below. Once this Docusign has been completed, a copy of the document will be emailed to you.

I, _____, hereby acknowledge that I have received and reviewed a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any question or complaints, I may contact:

West Village Eyecare Associates

10 Sheridan Sq, New York, NY 10014

212-242-6582 or westvillageeyecare@gmail.com

You may also contact the Secretary or the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____

Name: _____

Relationship to Patient: _____