Larchmont Mamaroneck Eye Care Group
933 Mamaroneck Avenue Suite 105
Mamaroneck, New York 10543

Name of Patient: __________________________ Date of Birth _________ SS# ___________________

Home Address _____________________________ City _______________ State _____ Zip _________

Phone # Home _____________________ Business ___________________

Party responsible for fees: ____

Address and phone if different from above: ______________________________________

INSURANCE INFORMATION
Do you have Vision Insurance? _____ Name of plan: _________________________ ID# ____________
Person responsible for insurance ____________________________Frequency of eligibility ___________
Does your coverage include Exam only _____
Exam & glasses _____
Exam & Contact Lenses _____

FOR CONTACT LENS WEARERS

If you have insurance which covers an eye exam and glasses there may be an additional fee for contact lens services. These services include evaluating the existing lenses, fitting of new lenses, or prescribing or reordering of additional lenses. Please indicate whether you want today's examination to include contact lens services.

____ I do want the doctor to provide contact lens services.

____ I do not want the doctor to provide contact lens services.

Primary medical insurance ______________________________ ID# ____________________________

SIGNATURE ON FILE STATEMENT: I authorize the release of all medical information necessary to process my health insurance claims. I also authorize payment of medical benefits directly to the Larchmont Mamaroneck Eye Care Group for all services rendered by them. In the event that my insurance denies payment due to lack of a referral or annual deductibles I will be financially responsible for all fees incurred and any additional charges necessary to collect these fees.

SIGNATURE: ____ DATE: ___________________________

Vision/Medical History Sheet

Date: ___________________

Patient's name ___________________________________ Occupation ______________________________

Special visual demands (work or hobbies) ____

Please indicate if you have ever had any of the following: (Circle)

Cataracts Glaucoma Macular degeneration Eye Infections

Lazy Eye Diabetes High Blood Pressure Allergies

List any other medical problems ____

List any medications you are presently taking ____

____

Are you allergic to any medications? Yes No (List)

____

Who is your family physician? ____

Have you ever had any injury or surgery to your eyes? Yes No

Describe ____

Have any bloodline relatives had glaucoma, or other loss of sight? Yes No

Describe ____

Do you presently wear glasses? Yes No

How old are the glasses? __________________ When do you wear them? __________________________

Do you presently wear contact lenses? Yes No

Hard Gas permeable Soft Disposable

If yes, how old are the contacts? ______________________________

If no, have you ever worn contacts? Yes No