NEW PATIENT QUESTIONNAIRE

Todays Date: ________________

Patient: ______________________ ______________________ __________
Legal Last Name — Legal First Name — Middle Initial

Date Of Birth: ______________ Age: __________ Sex: __________ Marital Status: __________

Address: ____ Apt# __________

City: ______________________________ State: ______________ Zip: __________

Home Phone: ______________________ Mobile Phone: ______________________

Patient's Social Security # ______________________ Prior Name: ______________________

E-Mail Address: ____

How would you like to be contacted for your appointment reminder? ☐ Home Phone ☐ Cell Phone

Do you authorize release of personal information? ☐ YES ☐ NO ☐ Medical ☐ Billing

Authorized Person: ____

How did you hear about us?: ______________________________

Other services offered at BFVC: ☐ LASIK ☐ Eyelid Surgery ☐ Botox ☐ Dry Eye Treatment
(Check box for more info)

Referring/Primary Optometrist: ____

Primary Insurance: ______________________ ID # ______________________

Secondary Insurance: ______________________ ID # ______________________

Medicare # ______________________ Medical # ______________________

Are you a member of a ☐ HMO ☐ PPO Is this for workers' compensation: ☐ YES ☐ NO

Do you have a flexible spending account? ☐ YES ☐ NO

Name Of Employer: ______________________ Occupation: ______________________

Employer's Address: ______________________ Employer's Phone # ______________

Name of Spouse: ______________________ Spouse's Social Security # ______________

Spouse's Employer: ______________________ Occupation: ______________________

Spouse's Date Of Birth: ______________________ Spouse's Work Phone # ______________

List medication you are currently taking: ____

____

Allergic to any medications: ____

____

Date of last eye exam: ______________________ Previous Eye Examiner: ______________________

Is there a family history of eye disease? ____

Previous Eye Surgery? ____

(OVER PLEASE)

Emergency Contact

Name: ______________________________ Phone: ______________________________

Relationship to Patient: ____

Name of spouse/parent or guardian if patient is a minor: ______________________________

☐ Spouse ☐ Parent ☐ Guardian

Address: ____

City, State, ZIP: ____

Social Security # ______________________________

Billing Information

Non-Insured Patients:
If you are not insured, it is our office policy here at Berg•Feinfield Vision Correction that payment is due at the time services are rendered unless a prior payment arrangement has been made.

I understand that I am financially responsible for payment of all charges incurred for services received from this office.

X ______________________________ ______________

Signature of Patient/Guardian if Minor Date

Insured patients:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

____

Name of Insurance Company(ies)

I assign directly to Berg•Feinfield Vision Correction all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible of all charges incurred for services received from this doctor's office whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X ______________________________ ______________

Signature of Patient/Guardian if Minor Date