BERG·FEINFIELD
VISION CORRECTION

NEW PATIENT QUESTIONNAIRE (Refractive)

Todays Date: _____

Patient: _____ _____ _____ _____
Legal Last Name | Legal First Name | Nickname | Middle Initial

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Best Number To Call: _____

Date Of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Patient's Social Security # _____ Prior Name: _____

E-Mail Address: _____

Would you like to be included in any of our company's promotional campaign via email? ☐ Yes ☐ No

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Whom may we thank for referring you to us? (please provide name): _____

other referral source if applicable: _____

Current Eye Doctor: _____ Date of Last Eye Examination: _____
Optometrist / Ophthalmologist

List medications you are currently taking: _____

allergic to any medications? _____

Is there a family history of eye disease? _____

Previous eye surgery? _____

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 # _____

Who do we contact in case of emergency? Name: _____

Telephone: _____ Relationship to Patient: _____

How long have you been considering Laser Vision Correction? _____

If you are a great candidate, how soon would you proceed? _____

I am interested in having laser vision correction for the following reasons:

GLASSES

☐ I dislike wearing glasses.
☐ I dislike my appearance with glasses.
☐ Inconvenient for sports and recreation.
☐ I hope to undertake a career that requires good vision (police, fire, pilot, etc,)
☐ I am concerned about functioning in an emergency.

Contact Lenses

☐ Contact lenses are inconvenient.
☐ Contact lenses are irritating/uncomfortable.

My profession is: _____ and need good vision for the tasks at work.

Hobbies and sports: _____

My expectations are that I must see:

☐ Perfectly without glasses or contact lenses.
☐ Much better than I do now without my glasses or contact lenses.

What is your major concern regarding Laser Vision Correction?

☐ Possible risks
☐ Possible discomfort
☐ Other: _____

(OVER PLEASE)

Primary Medical Insurance Company _____
Member Id # _____ Group # _____
Vision Insurance: _____ Member Id # _____
Flexible Spending Account (FSA) Employer: _____ Effective Date: _____ /_____/_____ Amount: $_____

We, at berg•feinfield vision correction would like to inform you of other services that we offer to our patients. If interested, please check all that apply:

Interest Free Financing
- ☐ 12 18 24 Months
- ☐ Carecredit

Cosmetic Eye Procedures
- ☐ Botox / Restylane / Perlane / Juvederm
- ☐ Reconstructive Eyelid Surgery
- ☐ Pterygium
- ☐ Dry Eye Treatment

Refractive Lens Implants
- ☐ Crystalens
- ☐ Monofocal
- ☐ ReSTOR
- ☐ Crosslinking
- ☐ EVO ICL
- ☐ Toric EVO ICL
- ☐ Toric IOLs

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

Office Use Only:

Date: _____/_____/_____ Changes: ☐ YES ☐ NO _____
BFVC SIGNATURE

Date: _____/_____/_____ Changes: ☐ YES ☐ NO _____
BFVC SIGNATURE

Date: _____/_____/_____ Changes: ☐ YES ☐ NO _____
BFVC SIGNATURE