Patient Information

Optical Fashions Dr D D Loewit & Associates

Name _____
(Title) (First) (Last) (Nickname) (M/F)

Address (Apt) (City) (State) (Zip Code)

Primary Phone Secondary Phone Email

Date of Birth Age SS #

Occupation Employer Employer Phone #

Employer Address (Street, City,State,Zip)

Emergency Contact Name, Relationship & Phone #

Medical Insurance (Please provide a copy of all insurance cards)

Name of Primary Insurance Member ID # Group #

Policy Holders Name Date of Birth Policy Holder SS# Relationship to Patient

Employer Employer Address (Street, City,State,Zip)

Secondary Insurance

Name of Secondary Insurance Member ID # Group #

Policy Holders Name Date of Birth Policy Holder SS# Relationship to Patient

Employer Employer Address (Street, City,State,Zip)

Vision Insurance

Name of Vision Insurance Member ID # Group #

Policy Holders Name Date of Birth Policy Holder SS# Relationship to Patient

Employer Employer Address (Street, City,State,Zip)

All co-pays (both medical and/or vision are) due at the time services are rendered. A minimum deposit of 50% is due prior to ordering any materials. The balance must be paid in full prior to receiving the materials. I hereby authorize payment directly to Optical Fashions/D D Loewit & Asso. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for services rendered on my behalf or by my dependents, whether or not paid by my insurance. I authorize this office to release any information required to secure the payments of benefits. I authorize the use of my signature below on all insurance submissions. I also realize that I am responsible for any unpaid balances not able to be submitted for insurance payments because I did not present the proper proof of insurance at the time of the appointment. Default of payment will subject account to all collection fees, including court costs and attorneys' fees if applicable.

Signature Date

(OVER)

Primary Care Physician _____ Phone _____

Current Medications (prescription/over-the counter) _____

Known Allergies (medications or other) _____

Date of Last Eye Exam (new patients only) _____ Date of Last medical exam _____

Do you currently wear Eyeglasses: Yes ☐ No ☐ Do you currently wear Contact Lenses: Yes ☐ No ☐

If you have a family history of the following, please designate which member by the following initials: Self(P), Mother (M), Father (F), Brother (B), Sister (S), Aunt (A), Uncle (U), Grandparent (GM or GF);

GENERAL:

1. Diabetes_____
2. High blood pressure_____
3. Heart disorders_____
4. Kidney disorders_____
5. Thyroid disorders_____
6. Multiple sclerosis_____
7. Tuberculosis_____
8. Allergies **(Yourself Only)**_____

OCULAR:

1. Glaucoma_____
2. Cataracts_____
3. "Cross Eyes"_____
4. "Lazy Eye"_____
5. Macular Degeneration_____
6. Night Blindness_____
7. Injury or surgery to **(your eyes)**_____ If yes, when and what type: _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS

Yes	No	
☐	☐	Do you have any permanent head or eye injuries?
☐	☐	Do your eyes itch, burn, or water excessively?
☐	☐	Are you troubled with frequent headaches?
☐	☐	Are you greatly bothered by bright lights?
☐	☐	Do you suffer from eye pain or strain?
☐	☐	Do you ever see double?
☐	☐	Do you see flashing lights in your vision?
☐	☐	Do you see things floating across your vision?
☐	☐	Have your pupils ever been dilated by an eye doctor?
☐	☐	Do you have particular difficulty driving at night?
☐	☐	Does your vision problem(s) interfere with your job/school?
☐	☐	Are you pregnant? (Months)
☐	☐	Do you smoke? (If yes, how many packs per day)
☐	☐	Are you presently under a physician's care?

PRE-EXAMINATION QUESTIONNAIRE

(if contact lens wearer)

What manufacturer and brand of contacts do you wear? _____
How long do you wear your contacts each day? _____
How many hours in today? _____
What solutions are you using? _____
Do you "rub" the lenses or use the "no rub" method of cleaning? _____
Do you clean your lenses in the morning or at night? _____
How old is your current pair of contact lenses? _____
How often do you change your lenses for new lenses? _____