DRS. SAVOY, SIEGEL & DESAI OPTOMETRIST

PATIENT INFORMATION DATE: _____

Thank you for choosing our practice for your eye care needs.
Please complete this form in ink.
If you have any questions or concerns, please do not hesitate to ask.

Last Name: _____ First Name: _____ M/F

Address: _____

City_____ State: _____Zip_____

Home Phone: ( ) _____Cell Phone: ( ) _____

DOB: _____Social Security Number: _____

Vision Insurance: _____ID/ SS _____

Medical Insurance:_____ID#_____

Employer Name:

_____

Email Address:

_____

*****PLEASE NOTE: THE BIRTH DATE IS REQUIRED TO OFFICIALLY CHANGE THE ADDRESS OF THE ABOVE SAID PATIENT. ALSO THE SOCIAL SECURITY NUMBER IS REQUIRED FOR INSURANCE VERFICATION PURPOSES. *******

Name:_____ DOB: _____
Name of Medical Doctor: _____ # _____
Pharmacy Information: _____
Last Eye Exam: _____ Reason for today's visit? _____
Emergency Contact: _____ Number ( ) _____

Medical and Ocular History (**PLEASE CIRCLE ANSWER)**

Disease/ Condition	**Patient History**	**Family History**
Cataract	YES OR NO	YES OR NO
Crossed Eye	YES OR NO	YES OR NO
Glaucoma	YES OR NO	YES OR NO
Cancer	YES OR NO	YES OR NO
Diabetes	YES OR NO	YES OR NO
High Blood Pressure	YES OR NO	YES OR NO
High Cholesterol	YES OR NO	YES OR NO
Asthma	YES OR NO	YES OR NO
Arthritis	YES OR NO	YES OR NO
Thyroid Disease	YES OR NO	YES OR NO
Anxiety/ Depression	YES OR NO	YES OR NO

List of Medications you take: _____
Are you currently taking any eye medications? Y/N _____
Do you have allergies to any medications? Y/N _____
Are you pregnant or nursing YES or NO?

<u>Do you presently have the following?</u>

Loss/Blurry Vision	YES or NO
Double Vision	YES or NO
Dryness	YES or NO
Sandy or Gritty Feeling	YES or NO
Itchy/ Burning/ Redness/ Tearing	YES or NO
Eye pain or Soreness	YES or NO
Flashes or Floaters in vision	YES or NO
Other	YES or NO

Drs. Savoy, Siegel & Desai Optometrists
127 Newark Ave.
Jersey City, NJ 07302
Tel: 201-333-2768
Fax: 201-333-3145

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment for my insurance companies.
I authorized payment direct to my doctor.
I permit a copy of this authorization to be used in place of original.

Name: _____
Signature: _____ Date: _____

Drs. Savoy, Siegel & Desai

Patient consent for use & disclosure of protected health information

With my consent, Drs. Savoy, Siegel and Desai may use and disclose protected Health Info (PHI) about me to carry out treatment; payment and healthcare Operations (TPO) please refer to our privacy practice for a complete description of such disclosures.

I have the right to review the Notice of Privacy Practice (NNP) prior to signing this consent. Drs. Savoy, Siegel & Desai may call or mail my home or other designated locations about any items that assist the practice in carrying out TPO, such as appointments, reminder cards, patient statements and test results. I have the right to request that Dr. Savoy, Siegel, & Desai restrict how I use or disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Drs. Savoy, Siegel & Desai may decline to provide treatment to me.

_____ _____

Print Name Signature

_____

Name of parent/ Guardian

PLEASE BE ADVISED…

If glasses OR contacts have not been picked up within 60 days of deposit, the deposit **<u>WILL NOT</u>** be reimbursed.

<u>Office Policy</u>

All refunds within the 60 days will be in form of store credit at our office

(Restrictions may apply)

Print Name _____

Date:_____ **X:**_____