Patient History (please print)

Contact Information

First Name:	SS#:	Age:	DOB:	Gender: M F
Last Name:	Home Phone:		Cell Phone:	
Address:	City:		State:	Zip:
Employer:	Work Phone:		Marital Status: M S W D	
Occupation:	E-mail:			
Emergency Contact:	Phone:			
Who may we thank for your referral?				

Medical History

Do you have **any** allergies? If yes, explain:

List **any** medications you take (**including over the counter**):

	Yes	No
Are you currently being treated for **any** medical condition? If yes, please explain:		
Past surgeries? (please list)		

Family History

Is there a family history of eye disease? If yes, please explain:

Do you smoke? If yes, how much:			Do you drink? If yes, how much:		
Have you ever had or been told that you have:			**Preferred Pharmacy:**		
General Eye Conditions	**Yes**	**No**	**General Health Conditions**	**Yes**	**No**
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):			Other (list):		

Eye History

When was your last exam?	Doctors Name/City:	
How old are your current glasses?	Do you wear contacts? Yes No	How old are your contacts?

When do you use glasses? Never Constantly Reading Only Distance Only Rarely

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible, co-pay or any balance not paid by your insurance. In order to control billing costs, it is the policy of Center for Ophthalmology & Laser Surgery (Michael Loeffler, MD & Davina Kirschenbaum, MD) that charges for office visits be paid at the time of each visit.

I accept financial responsibility for charges incurred on my behalf including costs of collection (if applicable). In the event that insurance is filed for surgery or other services rendered to me, I hereby authorized Center for Ophthalmology and Laser Surgery to release information to my insurance company and assign benefits directly to Michael Loeffler, MD & Dr. Davina Kirchenbaum should I have a remaining balance. Dr. Loeffler & Dr. Kirschenbaum reserves the right to charge a fee for any appointments canceled (including "no-show") with less than 48 hours notice. I understand that a test, called a Refraction may be done at the time services are rendered. This test must be performed in order to determine if a new pair of eyeglasses will im-prove my vision. As per Medicare guidelines (and most other insurance companies) this service is not a covered benefit by medical Ins. Dr. Loeffler or Dr. Kirschenbaum is not allowed to make any exceptions under Federal regulations. This test may be performed at any time that I come to in for services. I understand that I will be responsible for any additional charges at the time this service is performed.

______________________________ Patient Signature

____________________ Date