Hyde Park Optometry, P.C.
15 Park Place
Hyde Park, NY 12538
(845) 229-5281
HydeParkOptometry.com

PERSONAL INFORMATION

Patient:_____ **Birth Date:**_____**Age:**_____ **Sex:** F M
(Last) (First)

Prefer to be Called:_____ **Marital Status:** S M W D **Name of Spouse:**_____

Social Security #: _____

Occupation:_____ _____ **Employer:**_____ _____

Work Phone:(_____)_____

If Student, Grade/Year: _____ **School:**_____

Who may we thank for referring you to our office? _____

__ Internet Search __Insurance List __Reputation __Established Patient __Professional Referral __Other

ADDRESS

Street Address:_____ **City:**_____**State:**_____

Zip Code:_____

CONTACT INFORMATION

Home Phone:(_____)_____ **Cell Phone:**(_____)_____

Email Address: _____

In case of emergency, name a relative not living with you:

Name:_____ **Relationship:**_____

Street Address:_____ **City:**_____ **State:**_____

Zip Code:_____ **Home Phone:**(_____)_____

PAYMENT & INSURANCE

Person Responsible for Payment:_____ **Relationship to Patient:**_____

Street Address:_____ **City:**_____ **State:**_____

Zip Code:_____ **Phone:**(_____)_____

Occupation:_____ _____ **Employer:**_____ _____

Work Phone:(_____)_____

Insurance Information: Please list BOTH Vision Insurance and Medical Insurance (present both cards to the receptionist). Medically related eye examinations and procedures are covered under medical insurance while routine eye exams are covered under vision insurance.

Name of VISION Insurance Plan:_____

Primary Member's Name:_____ _____

Member ID Number:_____ **Member's Date of Birth:**_____

Name of MEDICAL Insurance Plan:_____

Primary Member's Name:_____ _____

Member ID Number:_____ **Member's Date of Birth:**_____

Name of Secondary MEDICAL Insurance Plan:_____

Please Note: If your insurance requires a referral, it must be obtained prior to your appointment. You will be responsible for payment if your insurance refuses to pay due to failure to obtain referral. Any applicable co-payments will be collected at the time of the exam. Patient acknowledges that should they not pay this account and it is assigned to a collection service, he/she will be liable for any collection fees charged by the agency plus any other collection.

Signature:_____ **Today's Date:**_____

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Poughkeepsie Optometry for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:_____ **Today's Date:**_____

Patient Name:_____ **Patient Birthday:**_____

MEDICAL HISTORY

Name of Primary Care Physician: _____ City:_____

Reason for Appointment:_____

Approximate Date of Last Eye Exam:_____ Previous Doctor's Name:_____

Have you ever worn glasses: Y / N **Have you ever worn contact lenses:** Y / N

If yes for contact lenses, what kind: __Soft __Rigid Gas Permeable __Daily Wear __Over Night

I would like more information about:

__Contact Lens Options __Laser Vision Correction __Dry Eye Treatment Options

__No Line Bifocals __Computer Glasses

Personal Eye/Ocular History:

Y / N **Glaucoma** Y / N **Cataracts** Y / N **Macular Degeneration** Y / N **Amblyopia/Lazy Eye**

Y / N **Strabismus/Eye Turn** Y / N **Iritis/Uveitis** Y / N **Retinal Tear/Detachment** Y / N **Eye Surgery**

Y / N **Eye Injury** Y / N **Flashing Lights** Y / N **Floating Spots** Y / N **Itching**

Y / N **Red** Y / N **Burning** Y / N **Tear** Y / N **Dry Other:_____**

Family Eye/Ocular History:

Y / N **Glaucoma** Y / N **Cataracts** Y / N **Macular Degeneration** Y / N **Lazy Eye**

Y / N **Retinal Detachment** Y / N **Blindness Other:_____**

Personal Health History:

Y / N **High Blood Pressure** Y / N **Diabetes** Y / N **Thyroid** Y / N **Stroke**

Y / N **Heart Disease** Y / N **Cancer** Y / N **HIV/AIDS** Y / N **Asthma**

Y / N **Allergies** Y / N **Cholesterol Other:_____**

Family Health History:

Y / N **High Blood Pressure** Y / N **Diabetes** Y / N **Heart Disease** Y / N **Stroke**

Y / N **Cancer Other:_____**

List ALL medications you are presently taking (including non-prescription drugs):

_____

_____

List ALL allergies you have to medications:

_____

_____

Personal Social History:

TOBACCO USE: __ Never Smoked __Former Smoker __If current smoker, how many years have you smoked?

ALCOHOL USE: __ None __Social Use __1-2 Drinks Per Day __Alcohol Dependent

NARCOTIC USE: __ None __Recreational Use __Chemical Dependent

Please indicate which of the following most accurately describes your race:

__ White __Black or African-American __Asian

__American Indian or Alaska Native __Native Hawaiian/Other Pacific Islander

Please indicate which of the following most accurately describes your ethnicity:

__ Hispanic or Latino __NOT Hispanic or Latino

Today's Date:_____