Sound Vision Care, Inc.

Date: _____ **ID#** _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: _____

Last Name: _____ **First**: _____ **MI**: _____

Home Phone: _____ **Cell phone**: _____ **Primary contact #** ☐ **Home** ☐ **Cell**

Mailing Address: _____

City: _____ **State**: _____ **Zip Code**: _____ SSN # _____

Date of birth: ____/____/____ **Age**: _____ **Height**: ____/____ **Weight (lbs)**: _____ **Sex**: ☐M ☐F

Race: ☐ African/African American ☐ Asian/Asian American ☐ Caucasian/Euro-American ☐ Other

Ethnicity: ☐ Native American/Native Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Hispanic/Latino ☐ Other

Employment Status: ☐Full-Time ☐Part-Time ☐ Not Employed ☐ Retired ☐Student ☐Disabled ☐Other

Occupation: _____ **Hobbies:** _____

Student: ☐ Yes ☐ No Grade: _____ If a minor, parent/guardian name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

To access your medical records, please provide an e-mail: _____

Family Physician: _____ Town: _____

Pharmacy: _____ Town: _____

Do you use tobacco? ☐ Yes ☐ No **Do you drink alcohol**? ☐ Yes ☐ No **Do you use recreational drugs**? ☐Yes ☐No

Do you have any medical conditions? ☐ Yes ☐ No if yes please list: _____

Do you take medications? ☐ Yes ☐ No if yes, please list: _____

Do you have any allergies to medications? ☐ Yes ☐ No if yes please list medications: _____

Have you had cataract surgery, or any eye surgery? ☐Yes ☐ No if yes please list: _____

Have you had other surgeries? ☐ Yes ☐ No if yes please list: _____

If female: Are you pregnant? ☐ Yes ☐ No **Are you Nursing**? ☐Yes ☐ No

Do any of the following apply to your eyes/vision: List any problems with your vision: _____

Y	N		Y	N		Y	N	
☐	☐	Contact Lens wearer	☐	☐	Double Vision	☐	☐	Sunlight sensitivity
☐	☐	Blurry Vision	☐	☐	Dryness of Eyes	☐	☐	Flashes of light
☐	☐	Crossed/Lazy Eye	☐	☐	Tearing Eyes	☐	☐	Floaters

What is the reason for your visit today? _____

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

For your medical records only, we need to keep a photo of each patient on file. Please sign below to give permission for us to take a photo to link to your medical record.

Patient Signature: _____ **Patient printed name:** _____

Continue on back, please complete other side

Sound Vision Care

Date: _____ ID# _____

ABN & HIPAA Consent

Bensonhurst
6806 Bay Parkway
(718)**236-4352** | fax (718)837-0783

Elmhurst
86-35 Queens Boulevard, Suite 1D
(718)**672-4888** | fax (718)672-4921

Forest Hills
71-19 Austin Street
(718)**268-7709** | fax (718)268-7739

Fresh Meadows
61-30A 190th Street
(718)**454-8484** | fax (718)454-8910

Manhasset
433 Plandome Road
(516)**627-0208** | fax (516)627-2929

Mastic
1360 Montauk Highway
(631)**281-2474** | fax (631)281-2476

Medford
1721 North Ocean Ave, Suite A
(631)**732-0822** | fax (631)732-0018

Murray Hill
458 3rd Avenue
(212)**696-5990** | fax (929)450-5101

Port Jefferson Station
524 Patchogue Road (Route-112)
(631)**476-4707** | fax (631)476-9632

Riverhead
1224 Ostrander Avenue
(631)**727-2858** | fax (631)727-2866

Southold
44210 Route 48, suite 1
(631)**765-3092** | fax (631)765-3046

Stony Brook
215 Hallock Road
(631)**675-6909** | fax (631)675-6910

Westhampton Beach
200 Montauk Highway
(631)**283-0220** | fax (631)283-0299

West Islip
502 Union Boulevard
(631)**422-2442**| fax (631) 492-9109

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www.soundvisioncare.com

AMERICAN OPTOMETRIC ASSOCIATION

NYSOA

patient name _____

Individuals Responsibility for Non-Covered Services
In consideration of services rendered by providers at Sound Vision Care Inc. to the undersigned patient, the undersigned promise(s) to pay providers at Sound Vision Care any co-payment, co-insurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided.

_____
signature of patient/parent

Assignment of Benefit Proceeds
I hereby assign to providers at Sound Vision Care Inc. all monies and/or benefits to which I am entitled from my insurance/HMO/third party payer, government agencies, or those who are financially liable for my medical care.

_____
signature of patient/parent

Authorization to Release Records
I hereby authorize providers at Sound Vision Care to release to my insurer/HMO/third-party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by paragraph 1 above, which are not medically necessary or improperly billed.

_____
signature of patient/parent

Authorization to Release Information
I hereby authorize providers at Sound Vision Care to release information pertaining to my medical care, materials, prescription information, notification of approval/denial of medications, arrival of any materials, information pertaining to insurance coverage, appointment reminders, and medical records I request, to the persons listed below (please indicate information restrictions if any):

Primary Care Physician:_____ Spouse:_____
Other:_____ _____ _____

_____
signature of patient/parent

Authorization to Communicate Through Text Messages
I hereby authorize Sound Vision Care to communicate through text with the cell phone number I provided. These texts can include appointment reminders, confirmations, and office experience feedback requests. A request can be made at any time to stop text communication.

_____
signature of patient/parent