Date: ____________ **ID:** __________

Sound Vision Care, Inc. –

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**: ____________ SS# ______________

Date of birth: _____/_____/______ **Age**: __________ **Height**: ________ **Weight**: __________ **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 any surgeries? ☐ Yes ☐ No if yes please list: ______________________

Have you had cataract surgery, or any eye surgery? ☐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:** ______________________

Continued on back...

Sound Vision Care, Inc.

Riverhead
887 Old Country Rd, Suites K-L
(631)**727-2858** | fax (631)727-2866

Southold
44210 County Rd 48, Suite 1
PO Box 463
(631)**765-3092** | fax (631)765-3046

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

Coram
3650 Route 112
(631) **732-0822** | fax (631) 732-00718

East Setauket
23 Technology Drive, Suite 5
(631) **675-6909** | fax (631) 675-6910

Jeffrey S. Williams Sr., OD
Comprehensive Optometry
Contact Lenses

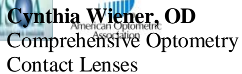
Massala P. Reffell, OD, MBA, MHA
Comprehensive Optometry
Contact Lenses
Disease Diagnosis & Management

Jeffrey S. Williams Jr., OD Dipl., ABO
Board Certified Optometrist
Comprehensive Optometry
Specialty Contact Lenses
Disease Diagnosis & Management

Monika Murawska, OD
Comprehensive Optometry
Contact Lenses

Cynthia Wiener, OD
Comprehensive Optometry
Contact Lenses

www.soundvisioncare.com



patient name___________________ **date**________ **ID#:**_________

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. ______
initial

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 date

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 date