

date: \_\_\_\_\_ ID: \_\_\_\_\_



Title:  Mr.  Mrs.  Ms.  Miss.  Dr.

Pronoun:  he/him  she/her  they/them

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Primary contact #  Home  Cell

Mailing Address: \_\_\_\_\_ Apt: \_\_\_\_\_

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

Create Patient Portal to access your records, e-mail: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Town: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

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 any medications?  Yes  No If yes, please list medications: \_\_\_\_\_

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: \_\_\_\_\_

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Blurry Vision                | <input type="checkbox"/> Double Vision                | <input type="checkbox"/> Sunlight sensitivity         | <input type="checkbox"/> Want a Contact Lens Exam?    |
| <input type="checkbox"/> Contact Lens Wearer          | <input type="checkbox"/> Dryness of Eyes              | <input type="checkbox"/> Flashes of light             |   |
| <input type="checkbox"/> Crossed/Lazy Eye             | <input type="checkbox"/> Tearing Eyes                 | <input type="checkbox"/> 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**

date: \_\_\_\_\_ ID: \_\_\_\_\_



# ABN & HIPAA Consent

patient name \_\_\_\_\_

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

Vision insurance companies do not pay for all of the portions of your exam. Portions of your exam may be billed to your medical insurance. In that event, you will have to pay the specialist copay and any balance that is not covered by your medical insurance or the amount that goes toward any deductible you may have.

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

You have \_\_\_\_\_ medical insurance with a specialist exam copay of \_\_\_\_\_ for the medical portion of the exam, and we will mail a bill for any fees that may apply to your deductible or that insurance did not cover.

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

You have \_\_\_\_\_ vision insurance with a \_\_\_\_\_ exam copay.

### Individual's 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 health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance.

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

✕ \_\_\_\_\_  
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.

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

✕ \_\_\_\_\_  
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.

**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

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

www.soundvisioncare.com

### 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

