**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**: _____ **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:** _____

**Continue on back, please complete other side**

Date: _____ ID# _____

# Sound Vision Care ABN & HIPAA Consent

**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 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

**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):

PCP:_____ Spouse:_____
Other:_____ _____ _____

_____
signature of patient/parent

**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)**732-082 |** fax (631) 732-00718

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

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

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

**Monika Murawska, OD**
Comprehensive Optometry
Contact Lenses

**Cynthia J. Wiener, OD**
Comprehensive Optometry
Contact Lenses

www.soundvisioncare.com