WELCOME

Thank you for selecting **Dr. I. David Nestorowicz**, Optometric Physician. We will strive to provide you with the best possible eye care. To help us meet all your eye needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

1 Personal Information

Date_____ Soc. Sec. #_____

Name_____ DOB_____

Male __ Female __ Minor __ Single __ Married

Address_____ City, State, Zip_____

Employer_____ Occupation_____

Referred by_____

Other members of your family who are our patients_____

2 Telephone

How would you like to be contacted :
□Phone_____□Text_____□Email_____

Work Phone_____ ext. #_____

When is the best time to reach you? _____
In the event of an emergency, who should we contact?

3 Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses and does not include a detailed examination of the retina. When a medical diagnosis or condition is present (such as high blood pressure, diabetes or eye disease) it is necessary to file the visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. Our office does not make these rules and they are defined by the insurance carriers themselves. There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Dr Nestorowicz' Office to file my insurance.

Signature_____ Date_____
Signature of patient or parent of minor _____ Date _____

Thank you for filling out this form completely. The information you have provided will help us serve your eye care needs more effectively and efficiently. If you have any questions at anytime, please ask, we are always happy to help you.

OPTICAL INFORMATION

General Information:

How many pairs of prescription glasses do you currently use? _____

If you wear single vision glasses are they (circle one)
For distance only For reading only For both distance and near

Do you wear Bifocals? _____ Trifocals? _____ Progressives (no line)?_____

Are you interested in or have you worn lenses that darken in sunlight? _____

Do you have prescriptions sunglasses? _____ Are they polarized? _____

What eyewear do you wear when driving? _____

What eyewear do you wear during the day? _____At night? _____

Are you bothered by bright light or reflections? _____

What feature do you like the most about your current glasses? _____

What feature do you like the least about your current glasses? _____

Are you planning to get new glasses today? (circle one)
Yes No Only if the prescription changes

Are you interested in finding out more about laser vision correction? (circle one)
Yes No Maybe

Contact Lens Information:

Do you wear contact lenses? _____ If yes:

How do you wear them? Sometimes All the time
Daily (take them out at night) Continuously (sleep with them in)

What type of lens? Hard (RGP) Soft Soft Disposable
Single Vision Mono–Vision Bifocal Eye-Coloring

Please indicate your contact lens brand if known:_____

Are you planning to get new contacts today? (circle one)
Yes No Only if the prescription changes

Occupational:

At work, do you read small print?_____ Do you perform fine or up-close work? _____

Is safety protection a concern?_____ Are you outdoors all or part of the time? _____

How much time do you spend on a computer daily? None 1-2 Hours 3-6 Hours More

Leisure Time:

What hobbies or recreational sports do you enjoy? _____

_____

Do you have any unusual visual requirements for your work or your hobbies? Please explain_____

_____