Please fax the completed forms to 212 448 0116

Patient Information

Last name: ____________________________________

First name: ______________________ Sex:________

SocSec #: _____________________________________

Address: _____________________________ Apt.___

City:________________ State: ______ Zip: ________

Birth date: __________ Phone #:________________

Employer: _____________________________________

Work phone #: _________________________________

Who referred you to our office? _________________

Patient's Doctor: _______________________________

Doctor's full address: ___________________________

____

Doctor's Phone #:______________________________

Spouse's Information

Last name: _____________________________________

First name: _____________________________________

SS #:____

Birth date:__________ Phone #: ________________

Employer: _____________________________________

Work phone #: _________________________________

Emergency Contact (if other than spouse)

Name: ____

Relationship____________________________________

Phone #: _______________________________________

Insurance Information Primary Coverage

Is primary coverage in the name of the patient or spouse?:___________________________

Insurance company name:___________________

Insurance ID: ____________________________

Employer name & address: ______________________

____

Work phone #: _________________________________

Insurance Information Secondary Coverage

Is secondary coverage in the name of the patient or spouse?:___________________________

Insurance company name:___________________

Insurance ID: ____________________________

Employer name & address: ______________________

____

I understand that Dr. Joshua Young will accept assignment for all insurance plans in which he is a participating provider. If I am a participating member of one of these plans on the date of service, I acknowledge that it is my responsibility to provide the correct insurance information, that I have satisfied my annual deductible (if applicable), and that I must provide a referral from my primary care physician dated on, or prior to, the date of service, if required by my insurance company. My medical billing data may be released to my insurance company or Medicare. I understand that if the above provisions are not met, I will be responsible for paying the usual fee charged for the services rendered. I have had the opportunity to review Dr. Young's privacy policy.

Signature____ Date ___________________________________

Medical Data

What is the reason for your visit today? Do you have any eye complaints?

____

____

____

Aside from your eyes, is there anything bothering you today (headache, seasonal allergies, etc)?

____

____

____

Allergies to medications: ____

Medications (other than eye medications)

name of medication	strength	how many times a day?

Eye Medications

name of medication	drop or ointment	which eye	strength	how many times a day?
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		
	DROP OINTMENT	RIGHT LEFT		

Medical Data - continued

Medical History

	YES	NO	DON'T KNOW		YES	NO	DON'T KNOW		YES	NO	DON'T KNOW
diabetes	☐	☐	☐	migraines	☐	☐	☐	cancer	☐	☐	☐
high blood pressure	☐	☐	☐	lupus	☐	☐	☐	blood disorder	☐	☐	☐
arthritis	☐	☐	☐	pneumonia	☐	☐	☐	pregnant	☐	☐	☐
skin problems	☐	☐	☐	stroke	☐	☐	☐	hepatitis	☐	☐	☐
heart disease	☐	☐	☐	asthma	☐	☐	☐	other			
immune disease	☐	☐	☐	thyroid disease	☐	☐	☐				

Eye History

	YES	NO	DON'T KNOW		YES	NO	DON'T KNOW		YES	NO	DON'T KNOW
dry eye	☐	☐	☐	conjunctivitis	☐	☐	☐	sty	☐	☐	☐
glaucoma	☐	☐	☐	cataracts	☐	☐	☐	other			
keratoconus	☐	☐	☐	herpes	☐	☐	☐				
uveitis	☐	☐	☐	corneal ulcer	☐	☐	☐				
retinal disease	☐	☐	☐	macular degeneration	☐	☐	☐				
eye lid problems	☐	☐	☐	retinal detachment	☐	☐	☐				

Have you ever had any sort of surgery? YES NO

What sort? ______________________________

Do you wear glasses for

distance? YES NO

reading? YES NO

Do you wear contact lenses YES NO

during the day? YES NO

to bed at night? YES NO

Do you smoke? YES NO

How many packs per day? ____________

For how many years? ________________

Do you drink alcohol? YES NO

How glasses per day? ____________

Wine Beer Other:________________

Family History

Do any eye problems (glaucoma, cataracts, etc.) run in your family?

1. Family Member__________________ Eye Problem ________________________ Age When Diagnosed ____
2. Family Member__________________ Eye Problem ________________________ Age When Diagnosed ____
3. Family Member__________________ Eye Problem ________________________ Age When Diagnosed ____
4. Family Member__________________ Eye Problem ________________________ Age When Diagnosed ____
5. Family Member__________________ Eye Problem ________________________ Age When Diagnosed ____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Young and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

____	________________________
Patient (or person authorized to sign for patient)	Date
____	________________________
Witness	Date

a word about contact lenses…

Contact lens fitting is the process of determining the correct prescription and design of contact lenses for patients with nearsightedness, farsightedness, astigmatism and presbyopia. Prescriptions for contact lenses are different from glasses prescriptions and require trying on contact lenses, often several pair. Contact lens prescriptions cannot be determined without trying contact lenses on.

Contact lens fitting is not covered by medical insurance. The fee for soft contact lens fitting is $250 and includes a supply of contact lenses. For most patients, a 6-month supply of 2-week or monthly disposable contact lenses will be included with the fitting, even if the prescription is for contact lenses which correct for astigmatism ("toric" lenses). A smaller supply will be given to patients requiring special contact lenses like colored lenses, high-astigmatism lenses, bifocal lenses and some dry-eye contact lenses.