FISHMAN CENTER
FOR TOTAL EYE CARE

Please provide/update your information:

Name: _____

Date of birth: _____

Address: Street: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Cell phone: _____

Home phone: _____

Insurance: _____

Primary care doctor: _____

Emergency contact name and phone: _____

Tell us who we can talk to about your medical care:

Name	Relation (e.g., parent, child, friend, neighbor)

PLEASE CONTINUE TO THE NEXT PAGE

FISHMAN CENTER
FOR TOTAL EYE CARE

Name: _____ DOB: / / Today's Date: _____

Please review and acknowledge the following:

- We participate in many health plans and accept assignment of benefits for plans that we are contracted with.
- Insurance copays are due at the time of the visit.
- A deductible may apply to your visit. This is your responsibility to pay and is determined by your contract with your insurance company.
- If your insurance plan requires a referral, it is your responsibility to bring it. It is your contract with your insurance company that determines whether you need a referral. If you do not have your referral, you will be responsible for all charges at the time of the visit.
- You are responsible for keeping your insurance active and informing us of any change in your insurance status. If your insurance plan is not active at the time of the visit, you will be responsible for all charges.
- Self-pay (no insurance) charges are due at the time of the visit.
- We do not accept vision plans or vision benefits. We will bill your medical plan for all services.
- If you have difficulty paying your bill, we can work with you on a payment plan.
- We do not accept worker's compensation cases.
- We do not prescribe contact lenses.

I acknowledge that I have read and understand and agree to the above. I also acknowledge that the Notice of Privacy Practices has been made available to me to read, and, if I requested, a copy has been given to me to keep. This is available at http://www.fishmaneyecenter.com/

_____ _____

Patient Signature **Date**

PLEASE CONTINUE TO THE NEXT PAGE

FISHMAN CENTER
FOR TOTAL EYE CARE

Name: _____ DOB: / / Today's Date: _____

Reason for your visit:

☐ Regular checkup or follow-up visit as directed
☐ Need glasses
☐ Driver's license (DMV) form or school form
☐ Referred by another eye doctor
☐ Second opinion
☐ Glaucoma
☐ Diabetic eye
☐ Macular degeneration
☐ Cataracts
☐ Other problem: _____

Are you using any eye drops? ☐ Yes (please list them below) ☐ No

Are you taking any medications? ☐ Yes (please list them below) ☐ No

Have you ever had laser or surgery in the eyes or eyelids? ☐ Yes (list below) ☐ No

Do you smoke? ☐ Yes ☐ Yes before, but not anymore ☐ No

Do you have any allergies? ☐ Yes ☐ No To what? _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No ☐ N/A

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No
Please note: We do not prescribe or renew contact lenses.

Who referred you here? _____

Preferred pharmacy: _____

Please list your eyedrops, medications, and previous eye surgery/laser here:

PLEASE CONTINUE TO THE NEXT PAGE

FISHMAN CENTER
FOR TOTAL EYE CARE

Name: _____ DOB: / / Today's Date: _____

REVIEW OF SYSTEMS

Do you have:

Diabetes	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes
High cholesterol	☐ No	☐ Yes
Heart disease	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Brain tumor/brain surgery	☐ No	☐ Yes
Heart rhythm problems	☐ No	☐ Yes
Thyroid problems	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
COPD	☐ No	☐ Yes
Rheumatoid arthritis	☐ No	☐ Yes
Lupus	☐ No	☐ Yes
Kidney failure/dialysis	☐ No	☐ Yes
Enlarged prostate	☐ No	☐ Yes
HIV/AIDS	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes
Cataracts	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Macular degeneration	☐ No	☐ Yes

Are you taking:

Flomax (tamsulosin)	☐ No	☐ Yes
Plaquenil (hydroxychloroquine)	☐ No	☐ Yes

Does anyone in your family have:

Blindness	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Macular degeneration	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes

Circle any of the following symptoms that you are experiencing TODAY:

General: Fever, tiredness, weight loss, night sweats, loss of appetite
Neurologic: Headaches, migraines, weakness, dizziness, numbness, feeling faint, memory loss
Head: Sore throat, dry mouth, pain when chewing food, scalp tenderness, hearing loss, sinusitis
Heart: Chest pain, palpitations, irregular heartbeat
Lungs: Shortness of breath, cough, coughing blood, wheezing
Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, bloody stool
Genitourinary: Pain or burning on urination, blood in urine, increased urinary frequency
Musculoskeletal: Joint pain, muscle aches, back pain
Skin: Rash, loss of hair, itching
Psychiatric: Anxiety, depression
Hematologic: Easy bruising, prolonged bleeding, enlarged lymph nodes
Allergic: Seasonal allergies, sneezing, hives
Any other symptoms: _____

_____ _____
Patient Signature **Date**