HUNTERDON FAMILY EYE CARE

Stephen L. Sinoway, O.D.
Devina P. Patel, O.D.

Welcome! Completing this form helps provide you with the best eye care possible. Thank you.

Name: Ms. Mrs. Miss Mr. Dr. Rev. ______________________________ *Friends Call Me:* ____________________
Address: ____ *City:* ______________ *State:* _____ *Zip:* ___________
Date of Birth: ___________________ *Age:* ______ *Social Security #:* ____________________________________
Home Phone: ___________________; *Work Phone:* ___________________; *Cell Phone:* ____________________
Email Address: _______________________________; *OK to receive HFEC office updates, events, and specials. Yes/No*
Occupation (if student, grade in school): ____
Employer (if student, name of school): _________________________________ Location: _________________________
Marital Status: Single___; Married ___; Divorced ___; Widowed ___; Name of Spouse: ______________________________
Name of Insurer for *Vision* Care: ____________________________ *Medical* Care: ________________________________
Name of Primary Holder: ____
Primary's Date of Birth: ___________________________; Primary's Social Security #: ___________________________
Reason for Today's Exam: ____
Medications you are taking or have recently stopped taking (include eye drops, birth control, hormones, and over the counter medications): ____
Allergies: Hay Fever ___; Sinus Problems ___; Drug Allergies ___ Explain: ____
Family Physician: __________________________ Office Location: ____
CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU: irritated eyes very light sensitive glare problems
frequent headaches lazy or crossed eye double vision eye or head injury eye surgery color vision defect
glaucoma cataract diabetes heart condition high blood pressure thyroid condition
other eye or medical condition ____
Have you *EVER* worn Contact Lenses -- Yes ___; No ___ What Kind? Soft ___; Daily Wear ___; Extended Wear ___;
Disposable ___; Rigid Gas Permeable ___; Hard ___ Manufacturer, if known: ______________________________
Do any immediate FAMILY members (parent, sister, brother, child) have EYE conditions or MEDICAL conditions? (Examples of eye conditions are: glaucoma, cataract, crossed eye). (Examples of medical conditions are: diabetes, high blood pressure, heart disease). Please explain: ____
____

HOW DID YOU FIND OUT ABOUT OUR OFFICE:

Name of Newspaper ______________________________; *Yellow Pages* ____; *Driving Past Office* ____; *Friend* ____;
Relative ____; *Healthcare Practitioner* ____; *Co-worker* ____; *Other* ____
Name of Person we may thank for referring you: ____

PAYMENT POLICY & RELEASE OF PATIENT INFORMATION

Payment is expected when services are rendered, unless other arrangements are made in advance. Insurance that covers your visit must be presented at time of visit, or the patient will be responsible for lab fees if glasses or contacts are not ordered from your insurance lab. Glasses must be dispensed to you within 60 days of purchase or they will be dismantled and deposit will be lost. The patient or responsible party will pay for services rendered which are not fully covered by an insurance or third party plan. If an account becomes delinquent, the patient will pay the balance plus reasonable collection agency and/or attorney fees and interest on the unpaid account.

For your protection, Contact Lenses may not be reordered without a yearly exam. Polycarbonate lenses (for eyeglasses) are recommended for all our patients, since they are the safest lens available.

I give my permission for this office to exchange exam or chart information with insurance or third party carriers and consulting doctors or professionals involved in my care. My consent is good for all future services.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS:

____ Date: ____________
(Signature of patient or responsible party)