Ins. Plan: _____ Date: _____

I.D. Number: _____ PCP: _____

Drs. Cukierman, Gomez & Associates

WELCOME TO OUR OFFICE

In order to provide you with the best possible eye care, please answer the following questions.

Name: _____ Birthdate: _____ Age: _____ M/F

Address: _____ Apt. # : _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Employer: _____ Occupation: _____

Health Ins. Plan (if applicable): _____ Medicaid #: _____

Primary Insured's Name: _____ Birthdate: _____

Date of Last Exam: _____ By Whom: _____ Date of last Medical Exam: _____ By Whom: _____

Medications: _____

_____

Allergies to Medications? _____

Whom May We Thank For Referring You? _____

Have you worn glasses previously? ☐ Yes ☐ No Have you worn contact lenses? ☐ Yes ☐ No

Are you interested in contact lenses? ☐ Yes ☐ No

Have you had refractive/ Laser Vision Surgery? ☐ Yes ☐ No If not, are you interested? ☐ Yes ☐ No

Do you have any hobbies/ activities that require a special eye care? ☐ Yes ☐ No (Computers, Sports, Cards, etc.) Other _____

Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No ☐ Only socially Other _____

MEDICAL AND OCULAR HISTORY – Please CHECK The Appropriate Box

	Yes	No	Year Diagnosed	Family
1 High Blood Pressure				
2 Diabetes (Insulin, pills, diet control)				
3 Thyroid				
4 High Cholesterol				
5 Heart disease				
6 HIV / AIDS				
7 Hepatitis				
8 Arthritis				
9 Cancer				
10 Sinus				
11 Allergies				
12 Headaches				
13 Other:				

	Yes	No	Year Diagnosed	Family
14 Eye Injury				
15 Eye Surgery including Laser				
16 Cataracts				
17 Cataract Implants				
18 Glaucoma				
19 Macular Degeneration				
20 Crossed Eyes				
21 Lazy Eye (Amblyopia)				
22 Floaters or Flashing Lights				
23 Blindness				
24 Are you taking any eye drops?				
25 Name of Drops:				
26 Other:				

I authorize the release of any medical information necessary to process this claim. I also request, authorize, and assign payment of all applicable benefits to the provider of these services, and agree to pay for any amounts not covered.

Patient or Legal Guardian's Signature: X _____ **Date:** _____

FOR DOCTOR'S USE ONLY

OC**Hx:** Last VF: Last Gonio: Target IOP OC **Meds:**