TODAY'S DATE: ____________________

BERG·FEINFIELD
VISION CORRECTION

UPDATED:
____
____
____

WELCOME QUESTIONNAIRE

PATIENT: ____
LEGAL LAST NAME — LEGAL FIRST NAME — NICKNAME — MIDDLE INITIAL

ADDRESS: ______________________ SP-APT# ______________

CITY: ______________________ STATE ______________ ZIP ______________

HOME TELEPHONE: ______________________ WORK TELEPHONE: ______________________

MOBILE PHONE: ______________________ BEST NUMBER TO CALL: ______________________

DATE OF BIRTH: ______________ AGE: ______________SEX: ______________ MARITAL STATUS: ______________

PATIENT'S SOCIAL SECURITY # ______________________ PRIOR NAME: ______________________

E-MAIL ADDRESS: ____

WOULD YOU LIKE TO BE INCLUDED IN ANY OF OUR COMPANY'S PROMOTIONAL CAMPAIGN VIA EMAIL? ❑ YES ❑ NO

Whom may we thank for referring you to us? (Please provide name)______________________

OTHER REFERRAL SOURCE IF APPLICABLE: ❑ WEBSITE / INTERNET: ______________________

❑ NEWSPAPER / MAGAZINE / RADIO AD ______________________ ❑ OTHER: ______________

CURRENT EYE DOCTOR: ______________________ DATE OF LAST EYE EXAMINATION: ______________
Optometrist / Ophthalmologist

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________

ALLERGIC TO ANY MEDICATIONS? ______________________

IS THERE A FAMILY HISTORY OF EYE DISEASE? ______________________

PREVIOUS EYE SURGERY? ______________________

NAME OF EMPLOYER: ______________________ OCCUPATION: ______________________

EMPLOYER'S ADDRESS: ______________________ EMPLOYER'S PHONE # ______________________

NAME OF SPOUSE: ______________________ SPOUSE'S SOCIAL SECURITY # ______________________

SPOUSE'S EMPLOYER: ______________________ OCCUPATION: ______________________

SPOUSE'S DATE OF BIRTH: ______________ SPOUSE'S WORK PHONE # ______________________

WHO DO WE CONTACT IN CASE OF EMERGENCY? NAME: ______________________

TELEPHONE: ______________________ RELATIONSHIP TO PATIENT: ______________________

How long have you been considering Laser Vision Correction? ______________________

If you are a great candidate, how soon would you proceed? ______________________

I am interested in having laser vision correction for the following reasons:

GLASSES
- ❑ I dislike wearing glasses.
- ❑ I dislike my appearance with glasses.
- ❑ Inconvenient for sports and recreation.
- ❑ I hope to undertake a career that requires good vision (police, fire, pilot, etc,).
- ❑ I am concerned about functioning in an emergency.

CONTACT LENSES
- ❑ Contact lenses are inconvenient.
- ❑ Contact lenses are irritating/uncomfortable.

OTHER REASONS:______________________
____

My profession is: ______________________ and need good vision for the tasks at work.

Hobbies and sports: ______________________

My expectations are that I must see:
- ❑ Perfectly without glasses or contact lenses.
- ❑ Much better than I do now without my glasses or contact lenses.

What is your major concern regarding Laser Vision Correction?
- ❑ Possible risks
- ❑ Possible discomfort
- ❑ Other: ______________________

(OVER PLEASE)

WELCOME QUESTIONNAIRE *(CONTINUED)*

PRIMARY MEDICAL INSURANCE COMPANY ____

MEMBER ID #__________________________ GROUP # __________________________

VISION INSURANCE:__________________________ MEMBER ID # ______________________

FLEXIBLE SPENDING ACCOUNT (FSA) EMPLOYER:______________ EFFECTIVE DATE:____/____/______ AMOUNT: $________

We, at **Berg•Feinfield Vision Correction** would like to inform you of other services that we offer to our patients.
If interested, please check all that apply:

INTEREST FREE FINANCING

- ❑ 12 18 24 Months
- ❑ CARECREDIT

COSMETIC EYE PROCEDURES

- ❑ BOTOX / RESTYLANE / PERLANE / JUVEDERM
- ❑ RECONSTRUCTIVE EYELID SURGERY
- ❑ PTERYGIUM

REFRACTIVE LENS IMPLANTS

- ❑ CRYSTALENS
- ❑ MONOFOCAL
- ❑ ReSTOR
- ❑ TORIC IOLs
- ❑ VISIAN ICL
- ❑ VISIAN TORIC ICL
- ❑ INTACS
- ❑ CROSSLINKING

BILLING INFORMATION

NON-INSURED PATIENTS:

If you are not insured, it is our office policy here at **Berg•Feinfield Vision Correction** that payment is due at the time services are rendered unless a prior payment arrangement has been made.

I understand that I am financially responsible for payment of all charges incurred for services received from this doctor's office.

X ______________________________________ ______________________

Signature of Patient/Guardian if Minor Date

INSURED PATIENTS:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

____

Name of Insurance Company(ies)

I assign directly to **Berg•Feinfield Vision Correction** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible of all charges incurred for services received from this doctor's office whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X ______________________________________ ______________________

Signature of Patient/Guardian if Minor Date

OFFICE USE ONLY:

DATE: _____/_____/______ CHANGES: YES ❑ NO ❑ ______________________________
EMPLOYEE SIGNATURE

DATE: _____/_____/______ CHANGES: YES ❑ NO ❑ ______________________________
EMPLOYEE SIGNATURE

DATE: _____/_____/______ CHANGES: YES ❑ NO ❑ ______________________________
EMPLOYEE SIGNATURE