TODAY'S DATE: _____

BERG·FEINFIELD
VISION CORRECTION

UPDATED:
_____
_____
_____

PATIENT: _____
LEGAL LAST NAME LEGAL FIRST NAME MIDDLE INITIAL

HOME TELEPHONE: _____ WORK TELEPHONE: _____

ADDRESS: _____ SP-APT# _____

CITY, STATE, ZIP: _____

SEX: _____ MARITAL STATUS: _____ PRIOR NAME: _____

PATIENT'S SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ AGE: _____

MOBILE PHONE: _____ BEST TIME TO CALL: _____

IN ORDER TO PROVIDE YOU WITH NEWS, UPDATES AND INFORMATION, PLEASE WRITE YOUR E-MAIL BELOW

E-MAIL ADDRESS: _____

HOW WOULD YOU LIKE TO BE CONTACTED FOR YOUR APPOINTMENT REMINDER CALL?

LAND LINE ☐ CELL PHONE ☐ TEXT ☐ E-MAIL ☐

DO YOU AUTHORIZE RELEASE OF PERSONAL INFORMATION? YES ☐ NO ☐ MEDICAL ☐ BILLING ☐
*(IF **YES**, PLEASE CHECK BOXES)*

AUTHORIZED PERSON: _____

HOW DID YOU HEAR ABOUT US? DOCTOR ☐ FRIEND ☐ INSURANCE ☐ WEBSITE ☐

OTHER SERVICES OFFERED: LASIK ☐ EYELID SURGERY ☐ BOTOX ☐ RESTYLANE ☐
(CHECK BOX FOR MORE INFO)

REFERRING / PRIMARY DR. _____

PRIMARY INSURANCE COMPANY _____

ID # _____

SECONDARY INSURANCE COMPANY _____

ID # _____

MEDICARE # _____ MEDICAL # _____

ARE YOU A MEMBER OF A: HMO ☐ PPO ☐ IS THIS A WORKERS' COMPENSATION: YES ☐ NO ☐

DO YOU HAVE A FLEXIBLE SPENDING ACCOUNT? YES ☐ NO ☐

NAME OF EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____EMPLOYER'S PHONE # _____

NAME OF SPOUSE: _____ SPOUSE'S SOCIAL SECURITY NO: _____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S WORK NO: _____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

ALLERGIC TO ANY MEDICATIONS? _____

_____

DATE OF LAST EYE EXAMINATION: _____ PREVIOUS EYE EXAMINER: _____

IS THERE A FAMILY HISTORY OF EYE DISEASE? _____

PREVIOUS EYE SURGERY? _____

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME: _____ TELEPHONE: _____

RELATIONSHIP TO PATIENT: _____

NAME, ADDRESS, TELEPHONE NUMBER OF RELATIVE NOT LIVING WITH YOU:

_____

_____

RELATIONSHIP: _____

NAME OF SPOUSE/PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

ADDRESS OF PARENT OR GUARDIAN: _____

CITY, STATE, ZIP: _____

SOCIAL SECURITY NO. OF SPOUSE/PARENT OR GUARDIAN: _____

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.

_____ _____

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.

_____ _____

Signature of Patient/Guardian if Minor Date