BERG·FEINFIELD
VISION CORRECTION

TODAY'S DATE: _____

WELCOME QUESTIONNAIRE

PATIENT: _____
LEGAL LAST NAME LEGAL FIRST NAME MIDDLE INITIAL

HOME TELEPHONE: _____ WORK TELEPHONE: _____

ADDRESS: _____ SP-APT# _____

CITY, STATE, ZIP: _____

MOBILE PHONE: _____ BEST TIME TO CALL: _____

E-MAIL ADDRESS: _____

SEX: _____ MARITAL STATUS: _____ PRIOR NAME: _____

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

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

AUTHORIZED PERSON: *(OTHER THAN PATIENT)* _____

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

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 want freedom from dependency on artificial devices.
_____ I am concerned about functioning in an emergency.
_____ Other reasons: _____

CONTACT LENSES

_____ Contact lenses are inconvenient.
_____ Contact lenses are irritating/uncomfortable.

My profession is: _____and need good vision for the following tasks at work:

1._____ 2._____

Hobbies and sports: _____

My current problem(s) with my glasses and/or contact lens(es) is/are:

1._____ 2._____

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: _____
❑ All of the above

(OVER PLEASE)

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: _____

PRIMARY INSURANCE COMPANY _____VISION INSURANCE:_____

GROUP # _____ POLICY # _____

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