PATIENT HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

CONDITIONS Check (✓) conditions you have or have had in the past.

☐ Blurred Vision	☐ Eye Pain or Soreness	☐ Loss of Side Vision
☐ Burning	☐ Eye Surgery	☐ Mucous Discharge
☐ Cataracts	☐ Foreign Body Sensation	☐ Prominent Eye
☐ Cross Eyes	☐ Floaters	☐ Redness
☐ Diabetes	☐ Glare/Light Sensitivity	☐ Retinal Disease
☐ Double Vision	☐ Glaucoma	☐ Seeing Flashes
☐ Drooping Eyelid	☐ Headaches	☐ Seeing Halos
☐ Dryness	☐ Hypertension	☐ Tired Eyes
☐ Eye Infection	☐ Lazy Eye	Other _____
☐ Eye Injury	☐ Loss of Vision	

Check (✓) if your blood relatives had any of the following		Relationship to you
	Blindness	
	Cataracts	
	Diabetes	
	Glaucoma	
	Other	

VISION CORRECTIONS

Do you wear eye glasses? ☐ Yes ☐ No

Please (circle)

Reading Distance Both

How old is your current prescription? _____

Do you wear contact lenses? Type _____

ALLERGIES you have to medications

Seasonal Allergies? Hay Fever?

MEDICATIONS List medications you are currently taking

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Number of packs per day _____

Do you drink? ☐ Yes ☐ No

Number of drinks per day _____

MAJOR ILLNESSES and INJURIES: Please list _____

SURGERIES: Please list _____

Have you or any member of your family experienced any problems with ANESTHESIA? ☐ Yes ☐ No

Please Complete Other Side

Navesink Eye
Your health is in our hands

225 State Hwy 35 N Suite 102 A
Red Bank, NJ 07701
732-889-3299
Navesinkeye@gmail.com www.Navesinkeye.com

Most people have vision insurance and medical insurance. While they seem similar, they are very different regarding the services they cover, and patients must understand those differences.

- Vision coverage (VSP, Spectera, Eye Med, Davis Vision, etc.) is mainly designed to determine a prescription for glasses and does not cover complex medical conditions.

- Medical coverage (BCBS, Cigna, UHC, Aetna, etc.) is filed when a medical condition is present such as diabetes, cataracts, dry eyes, floaters, etc. In this case, co-pays and deductibles for your medical insurance will apply.

Insurance carriers set these rules, and our office is required to follow them. We do our best to make sure you are aware of any out-of-pocket expenses associated with your visit. Unfortunately, in many incidences, there is no way to know before the examination which type of insurance our office will file for you.

We make every effort to be on every major carrier for your convenience, and we will file those claims for you. If we do not take your insurance, we will provide you with an itemized receipt so that you may file your carrier for reimbursement.

If you have any questions, please let us know.

I understand the paragraph above, and I authorized Navesink Eye to file my insurance by the above guidelines. I am aware that I am responsible for any co-payments or deductibles set in accordance with my insurance provider. I am also responsible for any treatment or testing that my insurance provider does not cover.

Signature: _____ Date:_____

Navesink Eye

Denise Balacich, OD

225 State Hwy 35 N, Red Bank, NJ 07701

732.889.3299

New Patient Information

Personal Information:

Name :_____ **Date**:_____

Date of birth: _____**Age:**_____**M/F**:_____ **SSN**:_____

Address: _____

_____

Email:_____

Marital status: Single_____Married:_____ Widowed:_____ Divorced:_____

Phone: home:_____ Cell: _____

Referred by: Friend /relative_____Previous pt:_____

Doctor_____

Family Doctor: _____Phone:_____

_____

If minor****

Name of father: _____Employer :_____

Address: _____Phone :_____

Name of mother: _____Employer :_____

Address: _____Phone :_____

Emergency Contact:_____ Phone:_____