

PATIENT HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

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

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

Check (✓) if your blood relatives had any of the following

	Blindness	Cataracts	Diabetes	Glaucoma	Other	Relationship to you
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

ALLERGIES you have to medications

Seasonal Allergies? _____ Hay Fever? _____

MEDICATIONS List medications you are currently taking

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 _____

SOCIAL HISTORY

Do you smoke? Yes No

Number of packs per day _____

Do you drink? Yes No

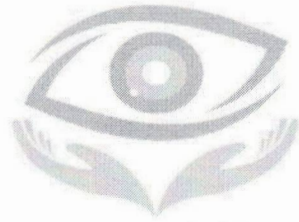
Number of drinks per day _____

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

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Your health is in our hands

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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

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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:** _____
