TOWN OPTICAL INC.
OPTOMETRISTS
551 Fifth Avenue, 2nd Floor
New York, NY 10176
(212) 719-4000

Dr. Eugene I. Cohen
Dr. Roy B. Cohen
Dr. Viktorya Belenkova
Dr. Steve D. Rubinstein
Dr. Julie Shah
Dr. Lisa Chen
Dr. Nicole Sangani

SIGNATURE ON FILE:

Patient Name: _____.
Social Security # _____.
Insurance Carrier: _____.

*I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
*I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
*I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
*I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
I* AUTHORIZE PAYMENT DIRECT TO MY DOCTOR.
*I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____.
DATE: _____.

Acknowledgment of Receipt and General Consent

ıowledge that I received a copy of Drs. Cohen, Cohen, Cohen, Rubinstein, Belenkova, Ettinger and Trans' e of Privacy Practices.

ıer consent to the release of my health information for purposes of treatment, payment, and health care tions and as authorized or required by law under the circumstances described in the Notice of Privacy ces.

Patient name _____

Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and urce of your authority to sign this form:

onship to Patient _____ Print Name _____
e of Authority: _____

"WELCOME TO OUR OFFICE" **TODAY'S DATE:**_____

Name: Last_____First_____ D.O.B._____

Address:_____ Gender Marital Status:

_____ (M / F) (S / M / D)

Phone: H#_____ W#_____ C#_____

E-Mail Address:_____

Insurance Information: (Important note: you will be held responsible for all co-pays, co-insurances, deductibles and contact lens evaluations if applicable.) These professional services are non-refundable. Please initial here._____

Occupation:_____ Employer:_____

Medical Insurance: _____ Policy# _____Group#_____

Optical Insurance: _____ Policy#_____Group#_____

Primary Care Physician:_____ Phone#_____

Policy Holder Name: _____Relationship to insured: _____

Policy Holder D.O.B: _____ Policy Holder SS#____/___/_____

Did anyone refer you to our office? Yes? No? If Yes, Who? _____

If Not, How did you hear about our office? _____

Would you be interested in having a complimentary laser vision screening today?_____→

*Please answer the following questions with Y for yes and N for no.
Do you feel a change is needed to see clearly at a distance? ___ near? ___.
Have you worn contact lenses before? ___ If yes, how long ago? _____.
If not, are you interested in becoming a contact lens wearer now? ___.
*When was your last **physical** exam?_____ Was everything normal?___.
Is there anything we should know about? _____
*Are you currently taking any medications? (prescribed or not prescribed)___
If yes, please list._____.
*Do you experience any of the following? Eye strain__ twitching eyelids__spots__
Pain of any sort__ If yes explain._____
*General history (past or present)
Use of tobacco products? __Recreational drugs?__Alcohol?__Allergies?__Asthma?__
Hay fever?__Drug sensitivities?__ High blood pressure?__ Diabetes?__ Headaches?__
Glaucoma?__ Eye diseases?__ Eye surgery?__ Eye or head injuries?__ Dizziness?__
*Does anyone in your immediate family have or has had?
Diabetes?__ Heart disease?__ Glaucoma?__ Tuberculosis?__ Blindness?__ Eye Disease?__
High blood pressure?__
*Please list any concerns or questions you might have for the Doctor._____
_____ _____.

Children living at home	**Age**	**Date of last exam**
1		
2		