SOUTHAMPTON OPTIKS	**DR TJ CALABRESE**
PATIENT INFORMATION	**INSURANCE INFORMATION**

Date: _________________

Name_______________________________________

DOB_______________________________________

Street_______________________________________

City/State______________________ Zip___________

Home Phone______________ Cell_________________

Email_______________________________________

Would you like to receive communications by:

☐ Text ☐E-Mail ☐ Phone

Who can we leave messages with?

☐Patient Only

☐Spouse

☐Anyone who answers the phone

Marital Status: Single Married Widowed Divorced

Soc Security #_________________________________

Employer: ___________________________________

Occupation: __________________________________

What is the main purpose of this visit?

☐Routine Eye Exam

☐Contact Lens Fitting

☐Eye Problem other than glasses/contacts

Vision Insurance _______________________________

ID#____

Subscriber Name: ______________________________

Subscriber DOB________________________________

Medical Insurance will cover testing or eye examinations in some cases. Please enter your information below so we can determine your coverage.

Medical Insurance______________________________

ID#____

Subscriber Name_______________________________

Subscriber DOB________________________________

Secondary Insurance____________________________

ID#____

Subscriber Name_______________________________

Subscriber DOB________________________________

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Declined

Race:☐White ☐Black or African American ☐Asian ☐American Indian and Alaska Native ☐Native Hawaiian and Other Pacific Islander ☐Decline

Ethnicity:☐ Hispanic or Latino ☐Not Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Decline

Privacy Practice Acknowledgement

A copy of Southampton Optiks Notice of Privacy Practices is available for review. Please look over this document if you desire, and sign below that you have had an opportunity to review it. Located at the front desk.

____

Signature

____

Date

Digital Retina Exam

Please check the appropriate box as to whether you would like to have a Digital Retinal Exam a $39 fee.

This is recommended annually. A Digital Retinal Exam provides: an eye wellness scan, an annual record for which gives your doctor a way to track small changes and diagnose potential eye disease. Please ask for more information at the front desk.

☐YES ☐ NO

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Dr. Calabrese all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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 submission.

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in diagnosis and/or treatment of my eyes.

____

Signature Date

EYE HISTORY

Last Eye Examination__________________

By Whom? ____________________________________

Do you wear glasses? YES☐ NO☐
☐ All the time ☐ Occasionally
☐ Reading Only ☐ Distance Only

Contact Lens Wearers Only:

What kind do you wear?____________________________

Cleaning solutions used: ____________________

How often do you replace your contacts? ______________

How often do you sleep in your contacts _______________
☐ ☐

Are you experiencing any of these symptoms since your last exam?

- ☐ Blurry Vision
- ☐ Red Eyes
- ☐ Burning
- ☐ Double Vision
- ☐ Discharge
- ☐ Flashes of Light
- ☐ Seeing spots
- ☐ Dry Eye
- ☐ Tearing
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Night Vision Problems
- ☐ Temporary Loss of Vision
- ☐ Other______________________

Have you ever been diagnosed or treated for any of the following?

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Eye Injury
- ☐ Retinal Disease/Detachment
- ☐ Blindness
- ☐ Eye Turn/Strabismus
- ☐ Lazy Eye/Amblyopia
- ☐ Diabetic Eye Problems
- ☐ Dry Eye
- ☐ Farsighted ☐ Nearsighted
- ☐ Other
- ☐ _____________________

Eye Surgery:________________

____
____

FAMILY MEDICAL/EYE HISTORY

Does anyone in your family have any of the following conditions? Please list the affected family members.

☐Glaucoma____________________
☐Cataracts____________________
☐Macular Degeneration__________
☐Retinal Disease_______________
☐Blindness____________________
☐Lazy Eye/Eye Turn____________
☐Diabetes_____________________
☐Cancer______________________
☐Heart Disease_________________
Other_______________________
____

How often do you consume alcohol?
☐Never ☐Occasional
☐Social ☐Moderate
☐ Heavy☐ Recovering

Smoking Status:
☐Never Smoker
☐Former Smoker
☐Current Every Day Smoker

Amount Per Day____________

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Blood Pressure:
_______ / _______
☐Low ☐Normal ☐High

Height: ______ ‘ ______”

Weight: _________lbs

MEDICALHISTORY

Primary Care Physician__________________________________

Last Physical Exam_____________________________________

Pharmacy____

Have you ever been diagnosed or treated for the following health problems?

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma/Emphysema/COPD
- ☐ Blood disorder
- ☐ Cancer, what kind? ___________________
- ☐ High Cholesterol
- ☐ Diabetes: Type 1 or Type 2
- ☐ Ears/Nose/Throat/Sinus
- ☐ Heart condition
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus/other autoimmune disease
- ☐ Migraine Headaches
- ☐ Muscle/Bone problems
- ☐ Pacemaker
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ Skin condition
- ☐ Stroke
- ☐ Other brain disease
- ☐ Thyroid
- ☐ Other not listed ___________
- ☐ ________________________

____

CURRENT MEDICATIONS

Including eyedrops, over the counter and vitamins

____
____
____
____
____
____

ALLERGIES

____
____
____
____
____

The information in this confidential case history form is critical to the evaluation of your vision and health.