Franklin Square Care

1040 Hempstead Tpke
Franklin Square, NY 11010
516-354-4242

New Patient Form

Name: _____
Last First MI

Address: _____
City State Zip

Home #: _____ Work/Cell #: _____ Email: _____

DOB _____/_____/_____ Age _____ Sex _____ Occupation _____

Medical Insurance _____ Member ID / SSN_____

Vision Insurance _____ Vision ID/SSN_____

If the patient is a dependent, name of parent/subscriber responsible for the account.

Name: _____ Relationship to patient: _____

DOB of Subscriber _____/ _____/ _____

Date of last eye exam: _____/_____/ _____ By whom? _____

Are you having problems seeing:
In the distance? ❑ Y ❑ N
Up close/reading ❑ Y ❑ N
At computers? ❑ Y ❑ N

If you wear contacts, what brand/type do you use? RGP ❑ Soft ❑ Brand: _____

Have you or your family members ever been diagnosed with any of the following conditions?

	Yourself	Family		Yourself	Family
High blood pressure	❑ Y ❑ N	❑ Y ❑ N	Cancer (type_____)	❑ Y ❑ N	❑ Y ❑ N
Diabetes	❑ Y ❑ N	❑ Y ❑ N	Glaucoma	❑ Y ❑ N	❑ Y ❑ N
Thyroid disorder	❑ Y ❑ N	❑ Y ❑ N	Macular degeneration (ARMD)	❑ Y ❑ N	❑ Y ❑ N
Heart disease	❑ Y ❑ N	❑ Y ❑ N	Lazy eye (Amblyopia)	❑ Y ❑ N	❑ Y ❑ N
High cholesterol	❑ Y ❑ N	❑ Y ❑ N	Eye turn (Strabismus)	❑ Y ❑ N	❑ Y ❑ N

Do you currently take any medications? ❑ Y ❑ N If yes, please list _____
Are you allergic to any medication? ❑ Y ❑ N If yes, which ones? _____
Any other known allergies? ❑ Y ❑ N If yes, to what? _____
Have you had eye surgery? ❑ Y ❑ N If yes, what kind and when? _____

INFORMATION ON MEDICAL INSURANCE PLANS

Medical insurance will only pay for medically related eye examinations which require a medical diagnosis. If the main reason for your visit is for a routine/yearly eye exam or contact lens check-up, your insurance plan may not pay and the patient is responsible for this fee.
Most insurance plans DO NOT pay for refractions (the part of the exam that checks for eyeglass prescriptions). The patient is responsible for this part of the fee.
Most medical insurance carriers and union plans do not pay for a contact lens evaluation or a contact lens fitting. The patient is responsible for this part of the fee.
Please initial _____

I authorize the release of medical information necessary to provide the most beneficial/complete visual examination. I understand that I am financially responsible for all charges whether or not paid for by insurance. Payment is due at the time services are rendered. Thank you!

_____
Signature of patient or responsible party