Perry S. Mollick, M.D., F.A.A.O.
Andrew P. Greenberg, M.D., F.A.A.O.

3509 Hempstead Turnpike
Levittown, New York 11756
T: 516.579.5400
F: 516.579.5437

PATIENT PROFILE

PATIENT INFORMATION: SEX: M ( ) F ( )

NAME: _____ **DATE OF BIRTH:**_____

ADDRESS: _____ SSN: _____-_____-_____

CITY: _____ STATE: _____ ZIP:_____

EMAIL ADDRESS: _____ MARITAL STATUS: ( ) MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED

Please check your preferred Contact Number:

( ) HOME PHONE::_____ ( ) CELL:_____ ( ) WORK:_____

PREFERRED LANGUAGE: _____ RACE: _____ ETHNICITY:_____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

RELATIONSHIP: _____

PRIMARY PHYSICIAN NAME: _____ PHONE:_____

ADDRESS: _____

EMPLOYMENT: ( ) EMPLOYED ( ) RETIRED ( ) UNEMPLOYED. ( ) OTHER

EMPLOYER: (NAME, ADDRESS, PHONE):_____

PHARMACY:

NAME:_____ PHONE: _____

TOWN: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE: _____

FAMILY MEMBER EXAMINED BY DR MOLLICK/DR GREENBERG: _____

PRIMARY INSURANCE: SECONDARY INSURANCE:

_____ _____

PHONE: _____ Phone: _____

I understand that I am receiving medical services from this office under the provisions of my managed care plan. I will be financially responsible for all deductibles, co-pays and co-insurances under the terms of my insurance contract. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such a referral If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account. If my insurance plan is not accepted by this office or is of the "indemnity type", I understand that I am financially responsible for all balances remaining after payment of insurance benefits. I hereby authorize and assign directly to Dr. Mollick/Dr. Greenberg all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. authorize the use of this signature on all my insurance submissions whether manual or electronic.

SIGNATURE:_____ PRINT: DATE:

MODERN EYES
OPHTHALMOLOGY

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MODERN EYES OPHTHAMOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____ acknowledge that I have received a copy of Modern Eyes' Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date

I authorize the disclosure of my private health insurance information to the following people:

Name Relationship Phone#

_____

FOR PRACTICE USE ONLY:

Modern Eyes made the following good faith efforts to obtain the above-referenced Patient' s written acknowledgment of receipt of the Notice of Privacy Practices:

Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.

Examples:

- Patient was asked to sign upon check-in but refused to do so
- Because of medical condition, Patient physically unable to sign acknowledgement

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EYE GLASS PRESCRIPTION FEE

KNOW YOUR INSURANCE PLAN

As a courtesy to you, our billing department will bill your insurance company for your visits in our office. Please remember, it is still your responsibility to know your insurance plan and benefits. In addition, if your insurance company does not make payment, you will be responsible for your bill.

At the time of service, you will be asked to complete a patient registration form and supply us with your current insurance card(s). If any of your insurance information changes throughout the course. of your care with us, please notify us right away.

Please be aware that most insurance companies do not cover routine eye exams. If you only have medical coverage and have no medical complaint or a medical diagnosis then you will be responsible for your bill.

Our doctors charge $40.00 for an eyeglass exam. This exam will only be done if necessary or upon your request.

I have read and understand the above stated policies.

Signature _____ Date _____

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SIGNATURE ON FILE (MEDICARE PATIENTS ONLY),

** **AS** you know Medicare pays 80% of their allowed amount. The other 20% will be submitted to your secondary insurance. If you do not have a secondary plan, you will be required-to pay the 20% at the time of service. Please try to keep this in mind for future visits.

Please be advised that we will collect Medicare deductibles at the beginning of the calendar year.

NAME (PRINT) MEDICARE NUMBER

I request that payment of authorized Medicare benefit be made on my behalf to this office for services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related service.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

We accept the charge determination of the Medicare carrier as the charge, and the patient responsibility only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE DATE

SECONDARY INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to this once. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan; I agree to pay them to this once. I' authorize this office to release any information required to process any and claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original

SIGNATURE DATE

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MEDICAL HISTORY FORM

NAME:_____ D.O.B. : _____ DATE: _____

Medical History: ☐ ***None***

☐ Angina	☐ COVID	☐ Hypothyroidism
☐ Anxiety disorder	☐ Depressive disorder	☐ Kidney disease
☐ Arrhythmia	☐ Diabetes - *Last A1C:* _____	☐ Migraine
☐ Arthritis	☐ Emphysema	☐ Sarcoidosis
☐ Asthma	☐ Epilepsy	☐ Sleep apnea
☐ Atrial fibrillation	☐ GERD	☐ Stroke
☐ Benign prostatic hyperplasia	☐ Hearing loss	
☐ Cancer	☐ High blood pressure	
☐ Congestive heart failure	☐ High cholesterol	☐ Pregnant/planning
☐ COPD	☐ Hyperthyroidism	☐ Nursing/Breastfeeding

Surgical History:

Please **select & date** any non-ocular surgery. ☐ ***None***

☐ Appendectomy	☐ C-Section	☐ Knee replacement (R / L)
☐ Back surgery	☐ Coronary artery bypass graft	☐ Mastectomy (R / L)
☐ Breast biopsy	☐ Excision of basal cell carcinoma	☐ Oophorectomy
☐ Gallbladder removal (Cholecystectomy)	☐ Hysterectomy	☐ Shoulder surgery (R / L)

Other:

Ocular History: *(Date of last Eye exam:_____)* ☐ ***None***

☐ Glasses	☐ Dry eye syndrome	☐ Macular degeneration	☐ Vitreous floaters
☐ Contact lenses	☐ Glaucoma	☐ Narrow Angles	
☐ Cataracts	☐ History of retinal detachment	☐ Strabismus	

Other:

Surgical Ocular History:

Please **select & date** any ocular surgery and/or treatment. ☐ ***None***

☐ Corneal Transplant (R / L)	☐ Blepharoplasty	☐ LASIK	☐ YAG Laser (R / L)
☐ Cataract surgery (R / L)	☐ Glaucoma (R / L)	☐ PRK	O *(after cataract surgery)*
By Dr. _____	By Dr. _____	☐ Strabismus surgery	O *(glaucoma treatment)*

Other:

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LIST **ALL** MEDICINES: INCLUDE DOSAGE (I.E. MG) & HOW MANY TIMES TAKEN DAILY

☐ ***None***

1)_____ 6) _____

2)_____ 7) _____

3)_____ 8) _____

4)_____ 9) _____

5) _____ 10) _____

Drug allergies ☐ ***None***

Please list, if any:

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No. If YES, how many packs daily? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, some days (2-3 days/week)
☐ Yes, occasionally/socially ☐ No

Family History:

Please indicate family member (blood relative) with any of the following:

☐ Glaucoma _____ ☐ Diabetes _____

☐ Macular degeneration _____ ☐ Autoimmune disease _____

☐ Keratoconus _____ (*Graves, Hashimoto, MS, RA, Sjogren, etc*)

Ocular Complaints:

Please check any of the following problems that you may have:

☐ Blurred/Poor vision	☐ Poor night vision	☐ Trouble reading street signs	☐ Glare from lights
☐ Halo around lights	☐ Trouble identifying colors	☐ Double vision	☐ Poor depth perception
☐ Flashes	☐ Floaters	☐ Eye pain	☐ Swollen lids
☐ Redness/Bloodshot	☐ Gritty sensation/Itching/burning	☐ Tearing	☐ Headaches

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REVIEW OF SYSTEMS: (Please check the box if you currently have any of these symptoms						☐ ***None***
INTEGUMENTARY/ ENDOCRINE:	☐ Fever ☐ Uncontrolled blood sugar	☐ Rash	☐ Skin disease	☐ Weight loss	☐ Dry, scaly skin	☐ itchiness ☐ ***None***
HEAD/NECK:	☐ Sinus problems	☐ Post-nasal drip	☐ Runny nose	☐ Stuffy nose	☐ Dry mouth	☐ Hearing loss ☐ ***None***
RESPIRATORY:	☐ Cough ☐ Congestion	☐ Bronchitis	☐ COPD	☐ Asthma	☐ Shortness of breath	☐ Emphysema ☐ ***None***
CARDIOVASCULAR:	☐ Chest pain	☐ Congestive heart failure	☐ Irregular rhythm		☐ Uncontrolled blood pressure	☐ ***None***
GASTROINTESTINAL:	☐ Vomiting ☐ Upset stomach	☐ Ulcers	☐ Diarrhea		☐ Bloody stools	☐ ***None***
GENITOURINARY:	☐ Genital ulcers ☐ Incontinence	☐ Blood in urine	☐ Kidney stones		☐ Discharge	☐ ***None***
ALLERGIC/ IMMUNOLOGIC & BLOOD/LYMPHATIC:	☐ Seasonal allergies ☐ Sickle cell disease	☐ Hay Fever	☐ Anemia		☐ Blood thinners	☐ ***None***
NEUROLOGIC, PSYCHIATRIC & MUSCULOSKELETAL:	☐ Headache ☐ Paralysis	☐ Migraines ☐ Arthritis	☐ Anxiety ☐ Tingling/Numbness		☐ Seizures ☐ Joint aches	☐ ***None***