Samuel Yankelove, MD

PATIENT INFORMATION

___New Patient ____Returning Patient

Patient Name: ________________________ Date of Birth: ___________ Age_______ Male/Female

Address: ____
Street City State Zip

Home Phone: ____________________________ Work Phone: ________________________

Cell Phone: _____________________________ Email: _____________________________

Your Social Security No: ___________________ Your Employer: ______________________

Referred by: ◻ Primary Care Physician ◻ Optometrist ◻ Friend/Relative ◻ Other

Name: ____

Address: ____
Street City State Zip

Medical Insurance (if applicable)

Plan Name: ____________________________ Insured Name: _______________________________

ID#: __________________________________ Date of Birth: _______________________________

Primary Insured SS#: ____________________ Employer: _____________________________

Vision Insurance (if applicable)

Plan Name: ____________________________ ID/SS#: ____________________________________

NOTIFICATION OF PATIENT RESPONSIBILITY FOR FEES

Some procedures, such as routine eye exams, measuring for glasses, contact lens fitting, special testing, cosmetic procedures and refractive surgeries, **MAY NOT BE COVERED BY INSURANCE.**

Payment of these services is your responsibility and must be paid for on the date of service.

If you have routine vision coverage, or think that you may be covered, please notify the receptionist on or before the date of service. This is necessary for us to comply with the terms of your plan.

While we make every effort to verify your coverage and file your insurance claim, the insurance company has the right to deny your claim. Should we receive notification that your claim has been denied for lack of coverage for the service, **payment of services is your responsibility.**

Assignment and Release: I request that payment of authorized Medicare or private insurance benefits are made on my behalf to Samuel J. Yankelove, M.D for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS), private insurance and their agents any information needed to determine these benefits or benefits payable for related services. This signature will be an “on file” authorization to file future forms with Medicare and other insurance companies and for the treatment of myself and/or my minor children. I am financially responsible for non-covered services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature: ________________________________ Date: ____________________________________

Print name: ________________________________

Samuel Yankelove, MD

Patient Health Information

Patient Name____ Date____________________

Reason for today's visit____

Please check below:
____ I am interested in wearing contact lenses
____ I would like more information on surgery that may reduce my need for glasses or contact lenses
____ I am interested in surgical correction of ___ Cataracts ___ Glaucoma

Are you having any of the symptoms below:

Yes	No		Yes	No	
___	___	Blurred vision with glasses	___	___	Eye Pain R___ L___ How long?___________
___	___	Halos or glare	___	___	Abnormal sensitivity to light
___	___	Difficulty reading	___	___	Scratchy eyes
___	___	Difficulty reading street signs	___	___	Itchy eyes
___	___	Poor side vision	___	___	Mattering
___	___	Double vision	___	___	Crusting
___	___	Flashes in vision	___	___	Excessive tearing
___	___	Night blindness	___	___	Headaches Location:______ How long?___

Other, please list:____
____

Do **YOU PERSONALLY** have a history of any of the conditions listed below:

Yes	No		Yes	No		Yes	No	
___	___	Diabetes	___	___	Arthritis	___	___	Tuberculosis
___	___	Hypertension	___	___	Thyroid problems	___	___	Other stomach ailments
___	___	Heart disease	___	___	Breathing problems	___	___	Ulcers
___	___	Cancer Type:_________________				___	___	Other ______________________

Please check if there is any **FAMILY** history of:
____Glaucoma ____Retina Disease ____ Other, please list:__________________________
____Cataracts ____Diabetes

List all medications you are currently taking, including over the counter medications:__________________

____

What eye drops are you currently using? ____
Are you allergic to any medications? ______**Please list:**____
Please list any previous eye surgeries or injuries to the eye:_______________________________________

Do you smoke? _______________ How much and how long? ________________________________
Do you drink alcohol? __________ Amount and frequency? __________________________________
Are you pregnant? _____________

Present visual correction:____Glasses: ____Bifocal ____Trifocal ____Reading
Contact lenses:____Rigid gas permeable ____Soft ____Disposable ____ Toric ____Bifocal
Are you pleased with your current prescription? ___ Yes ___ No If No, why?________________________________

____ __________

Patient Signature Tech Initials

Samuel Yankelove, MD

Permission to Release Health Information

I, the undersigned patient, give permission to release medical information as requested, regarding my eye health and prescriptions to the individuals listed below:

Please provide names of people who information can be released to:

Parent ____

Wife ____

Husband ____

Son ____

Daughter ____

Optometrist ____

Other______________________________

____
Patient Signature

____
Date