Welcome to Dr. Steven Wigdor's Eyecare & Eyewear Today's date _____/_____/_____

HAVE YOU EVER BEEN TO OUR OFFICE BEFORE? ☐ YES ☐ NO how did you hear about us? _____

NAME: _____ **GENDER:** ☐ MALE ☐ FEMALE
LAST FIRST

DOB: _____/_____/_____ **SS**: _____-_____-_____ **EMAIL:** _____@_____

ADDRESS: _____ APT _____

CITY: _____STATE: _____ ZIP: _____

CELL PH: ( ) _____ HOME PH: ( ) _____ WK PH: ( ) _____

If patient is a minor

PARENT NAME: _____ DOB: _____ SSN: _____

MARITAL STATUS:	☐ Married ☐ Single ☐ Divorced ☐ Widow		**Hispanic** or Latino origin ☐ Yes ☐ No	
RACE:	☐ African American	☐ Caucasian	☐Haitian	☐ Asian
☐ Haitian	☐ Native American	☐ Indian	☐ Pacific Islander	☐ Other

S O C I A L H I S T O R Y

WHAT IS YOUR OCCUPATION/EMPLOYMENT? _____

List your Hobbies _____

Do you smoke/chew tobacco?	☐ YES ☐ NO ☐ Quit date _____/_____/_____	How many packs per day?
Do you drink alcohol?	☐ YES ☐ NO	Amount per day
How many hours a day do you use computer?		

O C U L A R H I S T O R Y

LAST **EYE** EXAM: _____/_____/_____ EXAMINER: _____ ( ) _____
DATE OF LAST PRIMARY PH
PHYSICAL EXAM: _____/_____/_____ CARE PHYCISIAN: _____ ( ) _____

Have you ever had any of the following surgeries?

☐ CATARACT SURGERY ☐ LASIK SURGERY ☐ RETINAL SURGERY ☐ OTHER EYE SURGERY _____
***IF SO*, WHICH EYE** ☐ Right ☐Left WHEN _____

Are you interested in learning more about…?
☐ WEARING CONTACT LENSES ☐ LASIK VISION CORRECTION ☐ DRY EYE RELIEF ☐ LATISSE EYELASH ENHANCER

PLEASE CHECK ALL THAT APPLY TO YOU	
☐ **SEEING FLOATERS**	☐ DIFFICULTY READING SMALL PRINT (*NEWSPAPER*)
☐ HAVE EXCESSIVE ITCHING/TEARING	☐ **DIFFICULTY READING TRAFFIC SIGNS/WATCHING TV**
☐ **EXPERIENCE SENSITIVITY TO LIGHT/GLARE**	☐ SPEND TIME PLAYING OUTDOOR ACTIVITIES
☐ EXPERIENCE GLARE WHILE DRIVING AT NIGHT	☐ **DIFFICULTY DOING FINE WORK LIKE SEWING**
☐ **EXPERIENCE EYE STRAIN USING THE COMPUER**	☐ EXPERIENCE HEADACHES (more than 1 per week)
☐ EXPERINCE BLURRED/DOUBLE VISION	☐ **READ BOOKS/ STUDY FOR MORE THAN 2 HOURS A DAY**
☐ **SEEING FLASHES/HALOS AROUND LIGHTS**	☐ OCCUPATION INVOLVES POSSIBLE EYE INJURY
☐ EXPERIENCE BURNING OF EYES	☐ **HAVE DRAINAGE/MUCUS FROM EYES**

VISION HISTORY (Please check if you (SELF) have had any of the following conditions, anyone in your family (FAM) or if not they do not apply select NA) **PLEASE ANSWER ALL QUESTIONS**

	SELF	FAM	N/A		SELF	FAM	N/A		SELF	FAM	N/A
Lazy Eye	☐	☐	☐	Crossed Eyed	☐	☐	☐	Herpes Eye Disease	☐	☐	☐
Blindness	☐	☐	☐	**Diabetic Retinopathy**	☐	☐	☐	**Keratoconus**	☐	☐	☐
Cataracts	☐	☐	☐	Eye Injury	☐	☐	☐	Macular Degeneration	☐	☐	☐
Color Blindness	☐	☐	☐	**Glaucoma**	☐	☐	☐	**Retinal Detachment**	☐	☐	☐

MEDICAL HISTORY

Are you being treated/ diagnosed with any of the following medical conditions?

YES	NO	CONDITION *If you carry a current list with you, allow us to make a copy*	Medication Name	Dosage	Prescribing doctor
☐	☐	Allergies			
☐	☐	Blood Disease (**Anemia**)			
☐	☐	Breathing Problems			
☐	☐	Diabetes (**Type I or II**)			
☐	☐	Headaches/Migraines			
☐	☐	Hearing Impairment			
☐	☐	Cardiovascular (Heart, **High Blood Pressure**)			
☐	☐	Respiratory (**Asthma**, Emphysema)			
☐	☐	Gastrointestinal (Stomach, Ulcer)			
☐	☐	Muscles, Bones, Joints (**Arthritis**)			
☐	☐	Skin (**Acne, Skin Cancer**)			
☐	☐	Neurological (Multiple Sclerosis, **Headaches**)			
☐	☐	Psychiatric (**Anxiety, Depression**)			
☐	☐	Thyroid Problems			
☐	☐	Blood/Lymph (**Anemia, HIV**)			
☐	☐	Allergic/Immunologic (Lupus, Hay Fever)			
☐	☐	Genitourinary (**Kidney, Bladder, Prostate**)			
☐	☐	Ear, Nose, Throat			

Are you allergic to any medications? Y N If yes, please list:

_____

INSURANCE AND OTHER IMPORTANT INFORMATION

APPOINTMENTS & LATE ARRIVALS: We require patients to arrive on time for their appointments. When patients arrive late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may either be rescheduled so that other patients are not inconvenienced or if you prefer to wait, you may be seen if the day's schedule permits.

NO SHOWS: We expect patients to give us notice (24 hours prior) if they are not going to keep their appointments. When you make a commitment to an appointment, other patients lose the opportunity of scheduling that date or time. Giving us sufficient notice allows us to schedule a patient on our wait list. The cancellation fee without notice is $25.00.

MY OWN FRAME: In the event that I chose to use a frame I did not purchase from your office within the past year. I understand that I cannot hold this office, the lab used to manufacture my lenses, and all necessary transport services responsible for loss or damage to my frame.

SELF PAY: If I do not have proof of insurance coverage at the time services are rendered, I understand that full payment is due at the time of service.

TEXT & EMAIL will only be used by our office and will never be given or sold to others. I give permission to occasionally send information or marketing messages on behalf of the office of Dr. Steven Wigdor.

I ACKNOWLEDGE that I received a copy of Steven Wigdor, O.D., and Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS: I hereby assign payment to Dr. Steven Wigdor for all medical benefits applicable and otherwise payable to my insurance carrier including HMO, PPO, or any other third party payer for services rendered. I understand that I am financially responsible to Dr. Steven Wigdor for charges not covered by this assignment for any and all charges which the insurance carrier declines to pay. Where Medicare benefits are applicable, I authorize any medical information about me be released to the healthcare financing administration, or its subsidiaries for completion of any claims. I permit a copy of this authorization to be used in place of the original and I request payment of authorized benefits be made on my behalf to Dr. Steven Wigdor for any services provided under Medicare assignment of benefits regulations.

INSURANCE NAME: _____ INSURED DOB: _____/_____/_____

MEMBER ID: _____ NAME OF INSURED: _____

INSURANCE NAME: _____ INSURED DOB: _____/_____/_____

MEMBER ID: _____ NAME OF INSURED: _____

By signing below, I acknowledge that I have provided accurate information on this form, and that I have read, accept and agree to all the terms and conditions listed under "Insurance and Other Important Information". I have had everything explained and I have had an opportunity to have all my questions answered.

_____ _____ _____

Name (please print) Patient Signature (or Guardian) Date

Dr. Steven Wigdor
Board Certified Optometric Physician

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3650 N. Federal Highway
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IMPORTANT TESTING AUTHORIZATION

Highly sophisticated cameras now allow us to provide you with a more thorough medical analysis of your eye. Our retinal imaging system takes a picture of your retina (the inside of your eye.) This procedure assists your doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, & other vision threatening conditions. The doctor highly recommends that you have retinal photography performed, especially if you are having:

- □ **1. Headaches**
- □ **2. Spots or flashes in vision**
- □ **3. A family history of glaucoma, diabetes, or high blood pressure**
- □ **4. High Cholesterol**
- □ **5. Reached the age of 40**
- □ **6. Never been examined in our office**

Our Corneal Topographer photographs and prints a three dimensional map of your cornea (the front surface of your eye). Being able to document and monitor even minor corneal changes is important for:

- □ **1. Early detection of Corneal Disease such as Keratoconus**
- □ **2. New or existing contact lens wearers**
- □ **3. Those considering or who have had LASIK or other corneal surgery**
- □ **4. Those with any corneal growths, dystrophies or abnormalities**

The photos will become part of our medical records and will be used for today's diagnosis and for comparison with photos from future exams. This allows your doctor to observe even the smallest amount of change from previous examinations. There are additional fees for these procedures of $24.00 per procedure, which is usually not covered by insurance.

Please check the appropriate lines below and sign at the bottom

Retina: _____ **I choose TO HAVE Retinal Photography performed.**

_____ **No, contrary to the doctor's recommendation, I choose NOT TO HAVE Retinal Photography performed and I understand the health risks involved.**

Cornea: _____ **I choose TO HAVE Corneal Topography Photography performed.**

_____ **No, contrary to the doctor's recommendation, I choose NOT TO HAVE Retinal Photography performed and I understand the health risks involved.**

_____
Signature

_____ _____
Printed Name **Date**