

DR THOMAS ANTONIAN DR LYN-MARIE BEHMKE DR ARMINE TAHMASSIAN DR LAWRENCE GINSBERG
OPTOMETRISTS

Patient Name: _____ Home Tel: (____) _____ - _____
Address: _____ Work: (____) _____ - _____
City: _____ State: _____ Zip: _____ Mobile: (____) _____ - _____
_____ Date of Birth: ____/____/____ Gender: _____
_____ Occupation: _____
Social Security: ____ - ____ - ____ Marital Status: _____

Primary Physician: _____

Eye History

Date of last eye exam: _____ where: _____

Reason for Today's Visit: _____

Primary Care Physician: _____ Phone Number: _____

Do you or anyone in your family have any of the following (please circle):

Glaucoma Macular Degeneration Blindness Diabetes High Blood Pressure

Have you ever had any of the following (please circle):

Eye Disease Eye or Head Injury Eye Surgery Eye Turn Lazy Eye Headaches

Primary Form of Vision Correction (please circle): Glasses Contacts None

Would you be interested in learning about contacts? Yes No

Medical Information

Current Medical Conditions: _____

Current Medications: _____ Allergies: _____

Do you smoke/chew tobacco: Y or N Do you consume alcohol: Y or N

Do you have vision insurance? Y or N If yes, name: _____

What Medical Insurance do you carry? _____

Please be advised that the patient is responsible for providing a current copy of his/her insurance card and information regarding any possible separate vision plan such as EyeMed, VSP, or Davis Vision. The patient is also responsible for obtaining and providing a referral when required by the insurance company. Without the required information it will be the responsibility of the patient to pay for the services rendered on the day of the visit. Please be aware that Medicare and many other health insurance companies will not cover charges for items which may include, but are not limited to, refractions or medical supplies, which may be part of your eye examination. Healthcare regulations require us to collect all co-payments, deductibles, and non-covered services fees or face charges of fraud. Non-covered services fees and co-payments are due on the day the services are rendered. I certify that I assign directly to Dr. Lyn-Marie Behmke 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 insurance. I authorize the use of my signature on all insurance submissions. This office may use my health care information and may disclose such information to Medicare or other insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Additionally, I acknowledge that I have been provided an opportunity to review the notice of privacy practices.

**Patient Signature: _____ Date: _____

If someone other than the patient completed this form, please write your name and the relationship to the patient.

Name: _____ Relationship: _____ Date: _____