**Montgomery County Eye Care**
**Dr. Paul Heyman & Dr. Adam Rubin**
**Optometrists**

# WELCOME TO OUR OFFICE

## PATIENT INFORMATION

**Last Name** ______________________________ **First Name**_________________________ **MI** ________ **Date** ________________

**Soc. Sec #** ______________________ **Date of Birth** ____________________ **Age** _______________ **Gender** M F

**Address** ____________________________________________ **City** ______________________ **State** _____ **Zip** ______________

**Home Phone #** _______________________________________ **Cell Phone #** ____________________________________________

**Email Address** _______________________________________ **Preferred Method of Communication** ______________________

**Employer Name** ______________________________________ **Work Phone #** __________________________________________

**Occupation** ___________________________________________ **Full Time Student** Y N

**Responsible Party Name (if minor)** _____________________________________________________________________________

**Emergency Contact Name** _______________________________________ **Phone #** ______________________________________

**How did you hear about our practice?** __________________________________________________________________________

## INSURANCE INFORMATION

**Primary Insurance** ___________________________________________________________________________________________

**Name of Primary Insurance Holder** _____________________________________ **Date of Birth** ___________________________

**Relation to Patient** __________________________________________________ **Last 4 #'s of Soc. Sec #**____________________

**Secondary Insurance (if any)** __________________________________________________________________________________

**Name of Primary Insurance Holder** _____________________________________ **Date of Birth** ___________________________

**Relation to Patient** __________________________________________________ **Last 4 #'s of Soc. Sec #** _____________________

**Please provide insurance card(s) to the office in order for them to make a photocopy.**

## VISUAL AND HEALTH INFORMATION

**What is/are the reason(s) for your visit today? (Please circle all that apply)**

| | | |
|---|---|---|
| General check-up | See floaters or spots | Blurred distance vision |
| New glasses | See flashes of light | Blurred intermediate vision |
| Lost or broken glasses | Eyes feel dry | Blurred near vision |
| Double vision | Eyes are red | Want contact lenses |
| Headaches | Eyes itch | Contact lens check-up |
| Eyes water | Pain in eyes | Bifocal contact lenses |
| Eyes burn | Other: ______________________________________ | |

**Do you or have you ever worn glasses?** Y N **If yes, what for?** Distance / Near / All the time

**Do you or have you ever worn contact lenses?** Y N **If yes, what type?** Soft / Gas Permeable / Toric

**If you wear disposable lenses, how often do you replace them?** ___________________________________________

**Approximate date of your last eye exam?** ___________________________________________________

## VISUAL AND MEDICAL HISTORY

**Have you had any of the listed ocular conditions? (Please circle all that apply)**

| | | |
|---|---|---|
| Glaucoma | Eye surgery | "Lazy Eye" (Amblyopia) |
| Cataracts | Eye injury | Retinal Disorders (macular degeneration, detachment, holes, tears) |
| NONE | Other: ___________________________ | |

**Has anyone in your immediate family had any of the above conditions? Y N**

**If yes, what relative and what condition(s)?** ___________________________________________

**Do you have any problems with the following systems or conditions? (Please circle all that apply)**

| | | | |
|---|---|---|---|
| Gastrointestinal | Nervous | Mental | NONE |
| Ear/Nose/Throat | Diabetes | Integumentary (skin) | |
| Cardiovascular | Genitourinary | Blood/Lymph | |
| Respiratory | High Blood Pressure | Other: ___________________________ | |

**Are you currently taking any medication? Y N If yes, please list.** ___________________________

_____________________________________________________________________________

**Do you have any allergies? Y N If yes, please list.** ___________________________________

_____________________________________________________________________________

**Do you have any allergies to medication(s)? Y N If yes, please list.** ___________________________

_____________________________________________________________________________

**Alcohol Use (circle one):** None / Social Use Only / 1-2 Drinks Per Day

**Tobacco Use:** Never Smoked / Former Smoker / Current Smoker Every Day / Current Sometimes / Current Smokeless Tobacco

I authorize Montgomery County Eye Care, LLC (Paul Heyman, O.D. and Adam Rubin O.D.) to release any information requested with respect to insurance claims, prescription authorization, and bills reflective of services rendered by the provider of service. I also authorize that payment of insurance benefits for services rendered are made to Montgomery County Eye Care, LLC (Paul Heyman, O.D. and Adam Rubin O.D.). I understand that I am responsible for any charges not covered by this authorization. I permit a copy of this authorization be used in place of the original.

Signature ___________________________________ Date ___________________________

I acknowledge that I have either received or reviewed a copy of the Notice of Privacy Practices for Montgomery County Eye Care, LLC.

Patient Name ________________________________ Date ___________________________

Signature _____________________________________________________________

**Doctor's Initials** ____________________ **Date** __________

**UPDATED Initials** ____________ **Date** __________

**Initials** ____________ **Date** __________