ROY Z. BRAUNSTEIN, M.D.

PATIENT INFORMATION SHEET

PATIENT NAME: _____ DATE OF BIRTH ____/____/____

ADDRESS: _____ CITY, STATE, ZIP _____

PHONE/CELL NUMBER: _____ SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____ SEX: O Male O Female

Marital status: O Single O Married O Widowed O Divorced OCCUPATION: _____

EMPLOYER: _____ EMPLOYER PHONE #: _____

IS THIS A WORK RELATED INJURY: O YES O NO DATE OF INJURY: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

PRIMARY INSURANCE COMPANY NAME: _____

ID #: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY NAME: _____

ID #: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

FINANCIAL POLICY: You, the patient, are responsible for all fees regardless of insurance coverage. As a courtesy, we will file claims to your insurance carrier on your behalf. You will be responsible for any copays at the time of service. Any co-insurance and/or deductibles applied by your insurance company will be your responsibility and payable within 30 days of your claim processing. You acknowledge that you are authorizing payment directly to this provider and understand that you are responsible for any amounts not covered by your insurance carrier. You are also authorizing the release of any part of your medical record to your insurance company that is necessary to obtain payment of your claims in any format that may be requested by your insurance carrier. You are responsible for providing our office with your most current insurance carrier. If your insurance carrier changes and you fail to notify our office, you will be responsible for any charges incurred regardless of your insurance carriers' contract with this office.

NOTICE OF PRIVACY PRACTICES STATEMENT: You acknowledge that you have received a copy of the Notice of Privacy Practices.

Your signature indicates that the information you have provided is true and correct and that you have read and understand the above disclosures.

X_____ X_____

Patient/Guarantor Signature Date

MEDICAL HISTORY

Patient Name: _____ Height _____ Weight _____

Who is your Primary Care Doctor? _____

Primary Care Doctor's location: _____

List any medications you are now taking (include dosage if possible):

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any allergies to medication _____

Do you take blood thinners, including aspirin? ☐ YES ☐ NO

Do you have diabetes? ☐ YES ☐ NO Is there a family history of diabetes? ☐ YES ☐ NO

Do you have Glaucoma? ☐ YES ☐ NO Is there a family history of glaucoma? ☐ YES ☐ NO

Do you have heart problems? ☐ YES ☐ NO Breathing problems? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO How many packs per day? _____ For how long _____ years

Do you drink? ☐ YES ☐ NO Daily or socially? (please circle) If daily, how much _____

Do you use any "street drugs"? ☐ YES ☐ NO Do you have a history of substance abuse? ☐ YES ☐ NO

Do you drive? ☐ YES ☐ NO Do you have visual difficulty driving? ☐ YES ☐ NO

Do you have problems driving at night? ☐ YES ☐ NO

Do you currently wear glasses? ☐ YES ☐ NO Do you wear contact lenses? ☐ YES ☐ NO

Have you ever had hepatitis? ☐ YES ☐ NO

When was your last eye exam? _____

Have you ever had any EYE INJURIES or EYE SURGERY? ☐ YES ☐ NO When? _____

Please list any major illnesses or surgeries affecting your health today _____

_____

Please check if you are experiencing any problems in the following areas:

☐ Blurred Vision	☐ Foreign Body	☐ Black spots/floaters	☐ Excess tearing/Watering
☐ Distorted Vision	☐ Double Vision	☐ Flashes of Light	☐ Glare/Halo
☐ Dryness	☐ Drooping Eyelid	☐ Eye Pain/Soreness	☐ Sandy/Gritty feeling
☐ Redness	☐ Itching	☐ Poor Near Vision	☐ Poor Distance Vision

Please list any other medical history information that you would like the doctor to be aware of: _____

_____

_____