Account*
For internal use

Schecter & Blumenfeld

DATE INITIAL

DATE

REGISTRATION INFORMATION

PATIENT INFORMATION

LAST NAME FIRST NAME MI BIRTHDATE SOCIAL SECURITY #

HOME ADDRESS CITY STATE ZIP SEX D MALE D FEMALE

SPOUSE'S NAME HOME* WORK* MARRIED STATUS: D MARRIED D SINGLE

Cell Phone #: Driver Lie. Number:

EMAIL ADDRESS

RESPONSIBLE PARTY/GUARDIAN INFORMATION

RESPONSIBLE PARTY NAME LAST RRST MI RESPONSIBLE PARTY HOME PHONE

RESPONSIBLE PARTY ADDRESS CITY STATE ZIP RESPONSIBLE PARTY SOCIAL SECURITY #

RESPONSIBLE PARTY EMPLOYER OCCUPATION RESPONSIBLE PARTY WORK PHONE

RESPONSIBLE PARTY EMPLOYER ADDRESS CITY STATE ZIP RELATIONSHIP TO RESPONSIBLE PARTY
DSELF D SPOUSE DSON DDAUGHTER

MOTHER'S NAME MOTHER'S BIRTHDATE FATHER'S NAME FATHER'S BIRTHDATE

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT: OCCUPATION EMPLOYMENT OR STUDENT STATUS:
PATIENTS EMPLOYER'S OR SCHOOL ADDRESS

D FULL-TIME n NOT EMPLOYED D SELF EMPLOYED

CITY STATE ZIP

D PART-TIME D RETIRED D ACTIVE MILITARY

EMERGENCY INFORMATION

NEXT-OF-KIN - Other than spouse RELATIONSHIP

NEXT-OF-KIN ADDRESS CITY STATE ZIP NEXT-OF-KIN PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE SOCIAL SECURITY # CARDHOLDER DATE OF BIRTH

GROUP NUMBER IDENTIFICATION NUMBER

ADDRESS CITY STATE ZIP PHONE

SECONDARY INSURANCE CARDHOLDER DATE OF BIRTH

GROUP NUMBER IDENTIFICATION NUMBER

ADDRESS CITY STATE ZIP PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
I hereby authorize direct payment to Schecter Blumenfeld and Mann, of any medical benefits payable to me for the services provided at Central Medical Clinic.
I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE
I hereby authorize **[YOUR NAME HERE]** to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance daims. This authorization shall remain in effect as long as charges are being submitted for insurance daim processing or as long as dictated by payer.

Patient Signature or Signature of Guardian or Parent Date

MEDICAL HISTORY QUESTIONNAIRE

Name ______________________________ Date ____________

Date of Birth   Date of last eye **exam**

List any **medications** you currently take (Rx and over-the-counter):

Do you have **allergies** to any medications? **YES** **NO**
If YES, list the medications:________________________

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, appendectomy):

Do you *currently* have any problems in the following areas? If YES, please provide additional information

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.?) **YES** **NO**

Have you ever had a blood transfusion?............. YES **NO**

Do you drink alcohol? .... YES **NO** If YES, how much? ____________

Do you smoke? .... YES **NO** If YES, how much? ____________ How many years? ___