Dr.Todd Cohan, O.D.

Patient Information: (Please Print)

(Please circle) Mr. Mrs. Ms. Miss Dr.

Name: ____ Date ___________________________________

Date of Birth ________ Age________ M / F Soc Security # ____________________________

Address ____

Street City State Zip

Phone: Home(___) ____________________________ Work (________) _______________________

Email: ____

Occupation:___________________________________ Employer _____________________________

<u>Complete if under 18 years or a student</u>

Name of Father _______________________________ Employer ______________________________

Name of Mother _______________________________ Employer ______________________________

Address _______________________________________ Phone (_________)______________________

Insurance Information

Subscriber's Name _____________________________ Subscriber's Date of Birth ___ / _____/_____

Patient's relation to Subscriber ____Self ______ Spouse ____ Child ____Other _________________

Subscriber's SS# / ID Number ____

Subscriber's Employer ____

Vision Insurance: ____ VSP ____ Eye med

Medical Insurance: ____ BCBS PPO ____ Humana Choice Care ____ Medicare

____ Aetna ____ Cigna ___ United Healthcare

If you are a member of the above Insurance plans, your insurance company will be billed directly for services/ materials less any applicable deductions (Copays, Co-insurance, etc.). **<u>Please provide your ID cards to the reception desk.</u>** If you have other medical / vision insurance we will be happy to assist you in submitting a claim on your behalf for reimbursement to you.

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. **It is the responsibility of the patient (or parent if minor) to pay any deductible amount, co-insurance, or any balance not paid by your insurance**
2. Payment is expected at time of service, unless other arrangements have been made in advance. *In cases of Divorce, the parent/Guardian present with the child will be responsible for payment.*
3. In the event Dr. Todd Cohan, O.D. are not participating providers in your health plan you will be expected to pay for all services and materials received.
4. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services
5. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment

Privacy: I acknowledge that I received a copy of Dr. Todd Cohan, O.D. Notice of Privacy Practices.

Signed (Patient or Parent if minor)__________________________________Date__________________

________________________ ___/___ /_______

In compliance with Federal guidelines please fill out this form completely.

MEDICAL HISTORY

Are you presently taking any medications? Y N Please List ____

Do you have any allergies? Y N If yes, what? ____

Have you ever had eye surgery? Please list type, which eye and approximate dates

R __________________________ L __________________________

Do you have or have you ever worn eyeglasses? Y N If yes, how old is current prescription? ____________

Do you wear or have you ever worn contact lenses? Y N If no, are you interested? Y N

If yes, how old is current prescription? ____________ Are the contact lenses comfortable? Y N

Type of contact lenses: Rigid Soft Toric Monovision Bifocal Disposable Other ______________

Do you work on a computer? Y N If yes, how many hours per day? ____________________________

Date of last eye examination ____________

FAMILY HISTORY

Does anyone in your family have or been treated for: (please circle)

Glaucoma	Retinal Problems	High blood pressure	Diabetes
Cataract	Thyroid Problems	Macular Degeneration	Turned or lazy eye

SOCIAL HISTORY ***This information is kept strictly confidential***

Do you use tobacco products? Y N If yes, how long: ____

Do you drink alcohol? Y N If yes, how long: ____

Do you use illegal drugs? Y N If yes, how long: ____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYSTEMS Do you currently have or have you had any problem in the following areas?

CONSTITUTIONAL			
Fever, weight loss/gain	Y	N	?
INTEGUMENTARY			
Skin condition	Y	N	?
NEUROLOGICAL			
Headaches/Migraines	Y	N	?
Seizures	Y	N	?
EYES			
Loss of vision	Y	N	?
Blurred Vision	Y	N	?
Distorted Vision/Halos	Y	N	?
Double Vision	Y	N	?
Dryness	Y	N	?
Mucous Discharge	Y	N	?
Redness	Y	N	?
Itching	Y	N	?
Burning	Y	N	?
Foreign Body Sensation	Y	N	?
Tearing/Watering	Y	N	?
Glare or Light Sensitivity	Y	N	?
Flashes/Floaters	Y	N	?
ENDOCRINE			
Thyroid/ Other Glands	Y	N	?

EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	Y	N	?
Sinus congestion	Y	N	?
Chronic Cough	Y	N	?
RESPIRATORY			
Asthma	Y	N	?
Chronic Bronchitis	Y	N	?
Emphysema	Y	N	?
VASCULAR/CARDIOVASCULAR			
Diabetes	Y	N	?
High Blood Pressure	Y	N	?
GASTROINTESTINAL			
Diarrhea/Constipation	Y	N	?
GENITOURINARY			
Genitals/Kidney/Bladder	Y	N	?
BONES/JOINT/MUSCLES			
Rheumatoid Arthritis	Y	N	?
Muscle/Joint Pain	Y	N	?
LYMPHATIC/HEMATOLOGIC			
Anemia	Y	N	?
Bleeding Problems	Y	N	?
ALLERGIC/IMMUNILOGIC	Y	N	?
PSYCHIATRIC	Y	N	?