Welcome to Dr Kenneth A. Weinberg's Office.

Today's date_____Technician_____

(**Please print**)

Title_____Last Name _____First_____MI_____Name you prefer_____

Address _____City_____State_____Zip _____

Home Phone_____Social Security #_____Date of Birth_____

Work Phone_____Occupation_____Employer_____

Cell Phone_____E-mail_____

Referred by: Patient(Who)_____Doctor(Who)_____Sign_____Phone Book_____Other_____

Emergency Contact _____Relationship_____Phone_____

Person Responsible for Payment_____Relationship_____Phone_____

Method of Payment Cash____Check ____Credit____Debit Card_____Insurance_____Other_____

Did you have a medical physical within 1 year?_____Date/Doctor of Last Eye Exam_____

Interested in Glasses?_____Type Last Worn_____Interested in Contacts?_____Type last Worn_____

List **ALL** medications (including birth control, OTC, etc.)_____

_____

_____

_____

List allergies (including medication allergies)_____

_____

REVIEW OF SYSTEMS

	SELF/ YES	FAMILY(who)
RESPIRATORY		
Asthma	☐	☐_____
Chronic Bronchitis	☐	☐_____
Emphysema	☐	☐_____
PSYCHIATRIC		
Depression	☐	☐_____
Other	☐	☐_____
GENITOURINARY		
Genitalia	☐	☐_____
Kidney/bladder	☐	☐_____
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐_____
Muscle Pain	☐	☐_____
Joint Pain	☐	☐_____
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐_____
Bleeding Problems	☐	☐_____
ENDOCRINE		
Thyroid	☐	☐_____
Other Glands	☐	☐_____
ALLERGIC/IMMUNOLOGIC	☐	☐_____
INTEGUMENTARY		
Skin Problems	☐	☐_____

	SELF/ YES	FAMILY(who)
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐_____
Heart Pain/Disease	☐	☐_____
High Blood Pressure	☐	☐_____
Lupus	☐	☐_____
NEUROLOGICAL		
Headaches	☐	☐_____
Migraines	☐	☐_____
Seizures	☐	☐_____
EAR, NOSE, MOUTH, THROAT		
Allergies or Hay Fever	☐	
Sinus Congestion	☐	
Runny Nose	☐	
Post Nasal Drip	☐	
Chronic Cough	☐	
Dry Throat/Mouth	☐	
GASTROINTESTINAL		
Diarrhea	☐	
Constipation	☐	
CONSTITUTIONAL		
Fever, weight loss/gain	☐	
OTHER	☐	

EYES	SELF/ YES	FAMILY(who)
Blindness	☐	☐_____
Double Vision	☐	☐_____
Crossed Eyes	☐	☐_____
Glaucoma	☐	☐_____
Macula Degeneration	☐	☐_____
Retinal Detachment	☐	☐_____
Blurred Vision	☐	☐_____
Distorted vision	☐	☐_____
Loss of Side Vision	☐	☐_____
Tired Eyes	☐	
Dryness	☐	
Mucous Discharge	☐	

	SELF/ YES
Redness	☐
Burning	☐
Itching	☐
Tearing/Watering	☐
Gritty Feeling	☐
Foreign Body Sensation	☐
Glare/ Light Sensitivity	☐
Eye Pain or Soreness	☐
Chronic Infection of Eye	☐
Stye / Hordeolum	☐
Flashes of Light	☐
Floaters in Vision	☐
Other	☐

Informed Consent

-Dilation: Pupil dilation is an important part of our comprehensive eye exam and is offered at no additional charge. A dilated pupil allows a much more thorough view of structures in the back of the eye. It may allow us to detect otherwise undiagnosed cataracts, glaucoma, diabetic retinopathy, macular degeneration, tumors, retinal detachments and many other serious conditions. The most common side effects are increased sensitivity to light and reduction in near focusing ability. Some farsighted patients may experience difficulty driving and may wish to schedule the dilation when they have a driver, but an office fee will be incurred. The effects of the dilating drops usually last 2 to 6 hours, but duration may vary.

I DO_____ DO NOT_____ want my eyes dilated. UP TO DOCTOR_____

-Polycarbonate Lenses: Polycarbonate lenses are the most impact resistant lenses available. They are strongly recommended for patients with compromised vision in one eye, patients who are active in sports or work with power tools, and patients under the age of eighteen. _____

-Consent to Treat: Each patient may choose to accept or decline treatment options. Treatment options include, but are not limited to, eye examinations, fitting for contact lenses, diagnostic procedures, medical treatment or referral for treatment.
I understand that I have the option to accept or decline the treatment options as offered and explained. _____

-Privacy Statement: Your privacy is important to us and we will strive to protect it. We will not disclose patient information to non-privileged parties. We will not sell any personal patient information to any third parties. Insurance plans require the release of information needed to disburse payments and ensure that adequate care was received. Medical referrals and co-management require the sharing of information for treatment purposes. We contact our patients to confirm appointments and to remind them of visits that are due. From time to time we will contact select patients to notify them of new treatment options available or promotional events.
I would like to be notified by mail_____ phone_____ fax_____ other_____

-Insurance Authorization / Payment Guarantee:
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below.
Signed_____ Date_____
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the physician or supplier of services.
Signed_____ Date_____

I agree that I am solely responsible for all charges related to my visit. I understand that I am responsible for any and all balances due after insurance payments have been applied. I understand that I am responsible for all fees and legal expenses related to the collection of my balance. I understand that there is a $30.00 returned check fee each time a check is processed and returned. A 1.5% monthly service fee will be added to delinquent accounts.
Signed_____ Date_____