ClearView Retina

2391 Bell Boulevard, Suite 204 · Bayside, NY 11360
o: 646-828-8660 · f: 718-764-6296
clearviewretina.com

Patient Information

Last Name: _____ MI: ____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

Date of Birth: _____ Social Security: _____ Sex: **M** **F**

Ethnicity: _____ Primary Language: _____

Employer: _____ Employer Address: _____

E-Mail: _____

Emergency Contact & Number: _____

Relationship: _____

If the Patient resides in a **Nursing Home / Assisted Living / Rehab**, please circle.

Name and Address _____

Responsible Party Information (If Patient is NOT the Insurance Holder)

Last Name: _____ MI: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Date of Birth: _____ Social Security: _____ Sex: **M** **F**

PAYMENT OF BENEFITS:

I authorize payment of benefits, as determined by the company, directly to Rodney P. Coe, M.D. PLLC. I agree that all charges that are not directly paid by my insurance company will be my responsibility.

X _____ Date: _____

MEDICAL RELEASE AUTHORIZATION (Dependent must also sign if not a minor)

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claim or medical care. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X_____ Date: _____

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MEDICAL HISTORY

What is the reason for today's visit? _____

Do you experience any of the following: (Please circle all that apply)

Blurry Vision **Vision Loss** **Floaters / Floaters**

Eye pain **Tearing** **Migraines/Headaches**

Name and **dosage** of current medications (include eye drops & over the counter meds):

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any allergies to foods/medications with reaction _____

Have you undergone any past surgical procedures? (Please list) _____

Do you have a history of eye problems, surgeries/procedures? _____

_____

Do you smoke? **YES** **NO** Height: _____ Weight: _____

How were you referred to our practice? _____

Eye Doctor (Name & City): _____

Primary Care Doctor (Name & City): _____

Specialty Doctors (Endocrinologist, Cardiologist, etc): _____

_____

Pharmacy (Name & City): _____