Reiniger Eye Care

First name_____MI _____Last name_____ ◯ Mr ◯ Mrs ◯ Ms ◯ Miss

Address_____ City_____St_____ ZIP_____

◯ Landline _____ ◯ Mobile _____ (check preferred) SSN _____-_____-_____

◯ Male ◯ Female ◯ Prefer not to answer Date of Birth _____

Are you a student? ◯ Yes ◯ No Occupation _____ Employer _____

Email _____ (we do not share this with anyone-internal use only)

Whom may we thank for referring you? _____

Are you at least 18 years of age and responsible for your own financial and medical decision-making? ◯ Yes ◯ No

If No, Name of Person Responsible_____

Relationship to Patient_____SSN _____-_____-_____ Telephone_____

Address_____ City_____St_____ ZIP_____

Is this your first eye exam? ◯ Yes ◯ No If No, where did you have your last exam?_____

Do you wear Eyeglasses? ◯ Yes ◯ No Do you wear Sunglasses ◯ Regularly ◯ Occasionally ◯ Never

Do you wear Contact Lenses? ◯ Yes ◯ No If no, are you currently interested in wearing contacts? ◯ Yes ◯ No

Do you use electronic devices (smartphones, iPads, computers) ◯ All the time ◯ Average ◯ Minimally

Do you experience symptoms of dry eye (redness, burning, tearing, etc)? ◯ Often ◯ Occasionally ◯ Never

Please describe your smoking status: ◯ Current Smoker ◯ Previous Smoker ◯ Never Smoked

Hobbies or activities with special visual needs _____

Please tell us of any eye surgeries, injuries or disease that you have experienced_____

_____

Are you having any current problems with your eyes? ◯ Yes ◯ No If Yes, please explain_____

_____

Please tell us of any medications that you are taking _____

_____

Please tell us of any allergies that you are aware of _____

Do you or your family members have a history of:

Diabetes	◯ I do	◯ Family member _____
High Blood Pressure	◯ I do	◯ Family member _____
High Cholesterol	◯ I do	◯ Family member _____
Glaucoma	◯ I do	◯ Family member _____
Macular Degeneration	◯ I do	◯ Family member _____
Cataracts	◯ I do	◯ Family member _____
Thyroid Problems	◯ I do	◯ Family member _____

Vision Insurance_____ ID #_____

Medical Insurance_____ ID #_____

Subscriber: Name _____ Date of Birth _____ SSN _____-____-_____

(Please bring cards or other proof of insurance if you wish that we submit a claim on your behalf)

With this signature I am acknowledging the following:

I give my consent to Reiniger Eye Care to provide vision and eye health care services to me; I have answered questions on this document truthfully and am aware that providing inaccurate or incomplete information to my eye care provider could endanger my eye health.

I have received a copy of the Reiniger Eye Care HIPAA Notice of Privacy Practices.

I authorize Drs Cohn and Reiniger PC dba Reiniger Eye Care to submit to my insurance company for payment on my behalf**. I understand that I am responsible for any fees not paid by my insurance company and that any predetermination of benefits by my insurance company is not a guarantee of payment.**

Signed_____

Print _____ Date _____