

Welcome to Somers Eye & LASER Center



Thank you for choosing Somers Eye Center for your eye care needs. This form will help us serve you better. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information (Please Print)

Name _____ Date _____ / ____ / ____
First MI Last
Address _____ City _____
State _____ Zip _____ Birth date _____ / ____ / ____
Home # _____ Work # _____ Cell # _____
SS# _____ - ____ - ____
(Necessary for Billing Purposes)

Please share your Email address, if you would like us to contact you on informative developments in eye care or special promotions

_____ @ _____.

Name of person responsible for this account _____
Relationship to patient _____ SS# _____
(Necessary for Billing Purposes)

Name of Primary Care Physician: _____
Phone # of PCP: _____

Person to contact in case of emergency _____
Phone # () _____

Are you currently wearing?

Glasses Prescription Sunglasses Contacts

Are you interested in?

Contacts "LASIK" Vision Correction Botox / Juvederm
 Night Driving Glasses free consultations Laser Hair Removal
 Prescription Sunglasses 0% Financing Cosmetic Procedures
 Sports Goggles visit our LASER Suite Skinceutical Products

- Please fill out the Reverse Portion of this sheet -

Health Information

Do you or anyone in your family have a history of the following?

- Diabetes Heart Condition High blood pressure Cataract
 Thyroid Turned or lazy eye Glaucoma Blindness

Please check any of the following conditions that apply to you:

- Frequent Headaches Drug allergies Pregnant
 Allergies Sinus Trouble Other
 Have given birth within the last 6 months

Please list all medications that you are currently taking:

Have you ever had any of the following:

- Eye Surgery Sensitivity to light Infection or disease
 Eye Injury Floaters or spots Double Vision
 Eye Strain Severe pain Poor near vision
 Eyes burn, itch, or water Medical Treatment Poor distance vision

How did you hear of us? _____

Authorization

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for my services. I agree to be responsible for the payment of all services rendered on my behalf for my dependents.

X

Signature of Patient or Legal Guardian

/ /

Date