WESTCHESTER
EYE CARE CENTER

Patient Name:____________________________ Parents Name (if a child):____________________________

Address: ____________________________________ City/ZIP:____________________________

Home Phone:________________ Work Phone: __________________ Cell Phone: __________________

Email:______________________ Birthdate: _____________ Age: ______ Occupation:________________

Referred By (*we would like to thank them*) ______________________ Is this your first time to this office? ☐YES ☐NO

☐Male ☐Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

INSURANCE Patient relationship to insured: ☐ SELF ☐ CHILD ☐ DEPENDENT ☐SPOUSE

Social security #:____________________________ Employer: ____________________________

Vision Plan:____________________________ ID#:____________________________

Medical Plan: ____________________________ ID#:____________________________

OCULAR & HEALTH HISTORY (please list all active diagnosis for medical & ocular history):______________________

____

Eye drops & medications used:____

Smoker? ☐ YES ☐ NO ☐ IN THE PAST Pregnant? ☐ YES ☐ NO Contact lens wear? ☐ YES ☐ NO ☐ INTERESTED

Dear Patient,

We would like to take a photograph of the back of your eye (retina) using a special retinal camera. This procedure is not included in your regular eye exam. We feel however that it is important in analyzing the present health status of the eyes and monitoring it in future years. It is the easiest way to catch eye diseases early such as glaucoma or eye cancers. No eye drops are used for this procedure.

If ever an eye disease is found during a routine retinal photo, we will be able to bill it to your medical health insurance provider.

Please indicate if you would prefer routine photos for you or your child. The fee is $10.00 total.

_____ **Yes**, I would prefer having routine retina photos taken _____ No, I elect to not have retinal photos taken

_____ I would like to discuss this procedure with the doctor

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of benefits to Jennifer Tabiza O.D. I understand that I will be financially responsible for payment of all charges, co-payments, and deductibles incurred for services rendered from this office:

Signature of patient or guardian:____________________________ Date:____________________