Patient's Name: (First)_____ (Last) _____

Address:_____

City:_____ State: _____ Zip:_____

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

Email Address:_____

Date of Birth:_____ /_____ /_____ Sex: M /F

Occupation:_____ Social Security Number:_____

Age of Present Glasses:_____ Months _____Years Last Eye Exam:_____/_____ / _____

Have you been to this office before?
Do you have a Vision Plan?**VSP/ Davis Vision/ Eyemed/ United Healthcare Vision/Union/ Other:**
Do you have Medical Coverage**? Aetna/BCBS/Cigna/ GHI/ Emblem/Medicare/Oxford/United Healthcare**
If you are here for a medical eye visit/eye problem, please list your preferred pharmacy (name and address with zip):
Do you have any of the following conditions: (circle) **Heart Problem/ Diabetes/Hypertension / Please list <u>ALL</u> OTHER CONDITIONS/MEDICAL HISTORY:**
Please list **<u>ALL</u> medications** that you are currently taking**:**
Please list **medication allergies**:
Do you use **eyedrops**? (if yes, please list name/brand)
Do you have **Glaucoma**? YES / NO **Family history of Glaucoma**?YES (relation)_____/ NO
Do you suffer from **headaches**?
Does sunlight or **bright lights** bother you? YES/ NO Do you have trouble with **night driving**? YES/ NO
Do you experience **dry eyes/watery eyes** regularly? YES/NO
Do you **frequently use a computer**? YES/ NO If yes, approx. how many hours per day?
Have you ever had **eye surgery**? (If yes, please list procedure and when)
Do you currently wear **contact lens**? YES/NO **Brand/ Prescription**:
Are you interested in a free Lasik surgery consult? YES/NO

AUTHORIZATION OF PAY BENEFITS TO PHYSICIAN:

MEDICARE SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO PEN OPTICAL FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION THEY NEEDED TO DETERMINE THESE BENFITS PAYABLE FOR RELATED SERVICES. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

SIGNATURE: _____ DATE:___/ ___/ ____

COMMERICAL INSURANCE SIGNATURE ON FILE

I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANC NOT COVERED BY MY INSURANCE CARRIER. A COPY OF THIS SIGNATURE IS A VALID AS THE ORIGNIAL.

SIGNATURE:_____ DATE:___/ ___/ _____

GUARDIAN SIGNATURE (IF A PATIENT IS A MINOR)_____

RELATIONSHIP TO PATIENT:_____ DATE: ___/ ___/ _____

Missed Appointments and Cancellation Policy

We appreciate you choosing Penn Optical for your eye care. Upon scheduling your appointment we require a credit card to keep on file. If you are unable to keep a scheduled appointment please give 24 hours advance notice. If less than 24 hours notice is given, you will be charged a $35 cancellation fee.
Thank You

Credit Card Number:_____ EXP DATE:___/ ___/ _____

Security Code:_____ Billing Zip Code_____

SIGNATURE:_____ DATE:___/ ___/ _____