

Sussex Eye Center

502 W. Market St. 17 Lighthouse Rd 32030 Long Neck Rd. 18335 Coastal Hwy.
Georgetown, DE Selbyville, DE Long Neck, DE Lewes, DE
856-2020 436-2020 947-2020 645-8881

Carl Maschauer, OD Jeffrey Hilovsky, OD Hayley Sprague, OD Aimee Parker, OD

Welcome To Our Office

Name _____	Date of Birth _____ Age _____
Street _____	SS # _____
City _____ St _____ Zip _____	Employer _____
Home Phone _____	Occupation _____
Cell Phone _____	Sex M / F **If a student current grade _____
Work Phone _____	S / M / D / W Spouse name _____
E-Mail address: _____	Hobbies _____
If Minor, Parent(s) name _____	
If Minor, Parent(s) work phone _____	How did you hear about our office?
Family Doctor: _____	

Eye System Review

Eye Pain / Soreness	Y / N	Blurred Vision	Y / N
Red Eyes	Y / N	Itchy Eyes	Y / N
Double Vision	Y / N	Light Sensitive	Y / N
Dry Eyes	Y / N	Watery Eyes	Y / N
Sandy / Gritty Eyes	Y / N	Cataracts	Y / N
Glaucoma	Y / N	Problem w/ Glare	Y / N
Headaches	Y / N	Floaters	Y / N
Flashes of Light	Y / N	Tired Eyes	Y / N

Personal Medical History

Stomach Disorders	Y / N	Headaches	Y / N
High Blood Pressure	Y / N	Diabetes	Y / N
Thyroid	Y / N	Asthma	Y / N
Breathing Disorders	Y / N	Cancer	Y / N
Skin Disorders	Y / N	Cholesterol	Y / N

Social History

Smoke	Y / N	Alcohol Use	Y / N
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Family Medical History

High Blood Pressure	Y / N	Diabetes	Y / N
Retinitis Pigmentosa	Y / N	Asthma	Y / N
Detached Retina	Y / N	Migraine	Y / N
Macular Degeneration	Y / N	Cancer	Y / N
Glaucoma	Y / N	Thyroid	Y / N

Where and When was your last eye examination?

HELP US HELP YOU, Please answer the following

- * Do you have more than 1 pr. of current RX glasses? Y / N
- * Do you feel the glasses you wear now are too heavy? Y / N
- * If you wear bifocals, do they work well for you? Y / N
- * When driving, day or night, does the glare bother you? Y / N
- * Do you spend a lot of time on the water or at the pool? Y / N
- * Do you spend a lot of time outdoors? Y / N
- * When watching TV is the screen blurry? Y / N
- * Do your glasses interfere with your recreational activities? Y / N
- * Do you spend more than 4 hours a day on a computer? Y / N
- * If you wear contact lenses, are you satisfied with the vision and comfort? Y / N
- * Are you interested in contact lenses? Y / N
- * Are you interested in contact lenses that change the color of your eyes? Y / N
- * Do you desire information regarding laser vision correction? Y / N

****PLEASE READ AND SIGN THE BACK****

Today's Date: _____

INSURANCE INFORMATION:

PLEASE NOTE THAT **SUSSEX EYE CENTER IS NOT RESPONSIBLE** FOR KNOWING YOUR INSURANCE POLICY, CO-PAYS, AND/OR REFERRAL AUTHORIZATION GUIDELINES.

DO YOU HAVE INSURANCE FOR MEDICAL AND/OR VISION COVERAGE? YES ____ NO ____
IF YES, PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST TO BE COPIED.

AUTHORIZATION:

1. I hereby authorize comprehensive eye examinations.
2. I am responsible for any co-pays or portion of fees my insurance does not cover. In addition, I agree to release medical information for processing an insurance claim.
3. I understand that several insurances do not pay for the refraction portion of the medical examination.
4. I authorize payment of the medical benefits to Sussex Eye Center, P.A. for services rendered.

I request that payment of authorized insurance benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the proper authorities & its agents any information needed to determine these benefits or the benefits payable for related service.

I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier. I authorize any holder of insurance information about me to release to the proper authorities any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____

(PATIENT / GUARDIAN / BENEFICIARY)