

BRAVERMAN EYE CENTER
PATIENT QUESTIONNAIRE and POLICIES
OFFICE HOURS 8:30 - 5:00 PM, Monday –Friday

Today's Date ___/___/___

Last Name _____, First Name _____ MI _____

Primary Insured's Name _____ Primary Insured's Date of Birth ___/___/___

Street Address _____

City _____ State _____ Zip Code _____ Age _____

Phone (H) _____ - _____ - _____ (W) _____ - _____ - _____ E Mail _____

Date of Birth _____ SSN _____ Sex M F

Marital Status S M D W Employer _____

Primary Language Spoken _____

Medical Insurance _____ ID# _____

Primary Insured's SS # _____

Supplemental or Additional Insurance _____ ID# _____

Medical Doctor _____ Phone _____ - _____ - _____

Whom may we thank for referring you to our office _____

*** If not referred, how did you hear of us? Radio /TV / insurance / yellow pages /friend /relative /newspaper/billboard**

I request that payment of authorized Medicare benefits, Medigap benefits or other insurance benefits otherwise payable to me be made directly on my behalf to Stanley Braverman, M.D. & Assoc. for any services furnished me by that physician. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits or the benefits payable for related services. I attest that the insurance information I am providing the Braverman Eye Center is accurate. If the information I have provided is incorrect and as a result office and/or surgical fees are incurred, I understand that I am responsible for the incurred balance. Should any diagnostic or surgical procedure be done that is later deemed non-covered by my insurance, or non-paid because the charge went towards my deductible, I, as the patient, am responsible for the charges. Restated, this is your insurance. If they tell us that you are authorized and covered for an office visit, office diagnostic test, and/or a surgical procedure and they later tell us that you are not covered, then you are responsible for the incurred charges. We will help you fight those charges to the best of our ability after payment has been rendered. If my insurance should change, I understand that I am responsible for notifying Braverman Eye Center of the change in writing and failure to do so may result in office and/or surgical fees for which I am responsible. I will cancel scheduled appointments at the Braverman Eye Center at least 24 hours in advance if I cannot keep an appointment. Failure to do so may result in a cancellation fee. Patients of this office can get eye medication refills while here for their appointment or, by dialing our main phone number and then pressing #24; follow the prompts when connected and ask to have a medication called in to the pharmacy. If calling after hours, leave a message including your name, the name of the medication and the name and number of your pharmacy and it will be called in the next day.

If your account is not paid in full at the time of your visit and you must be billed for outstanding balances, a charge will be assessed to cover the cost of each mailed statement.

The consultant sub-specialists who work at the Braverman Eye Center, including, but not limited to, **Dr. Eric Ciliberti, Dr. Alan Lane, Dr. Tirso Lara, Dr. Rashid Taher, Dr. David Tenzel, and Dr. Kevin Stewart** are all independent contractors. They are not employees of the Braverman Eye Center and the Braverman Eye Center has no control over the medical decisions made by these individuals, and is not responsible for their medical/surgical decisions and outcomes. **They may or may not be in network on your insurance.** It is your responsibility to check on this either with our office or with your insurance company.

During your exam your eyes may be dilated with drops. Dilation will impair your ability to walk or drive a vehicle for several hours. We recommend that you use caution while walking and that you do not operate a vehicle until the dilation effect has worn off. Also, I acknowledge that I have read the **Privacy Policies** that are posted in the waiting area.

Lifetime Patient Signature

Please complete other side also

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If "YES", please give an explanation. If no, please circle N.

Constitutional

Fever Y N _____
 Weight loss Y N _____
 Malaise Y N _____
 Fatigue Y N _____

Ears, Nose, Mouth, Throat

Sinus congestion Y N _____
 Chronic cough Y N _____
 Dry mouth/throat Y N _____
 Decreased hearing Y N _____
 Difficulty swallowing Y N _____

Cardiovascular

High blood pressure Y N _____
 Heart attack/angina Y N _____
 Arrhythmia Y N _____
 Heart failure/block Y N _____
 High cholesterol Y N _____

Respiratory

Shortness of breath Y N _____
 Wheezing Y N _____

Musculoskeletal

Muscle pain/weakness Y N _____
 Joint pain Y N _____

Integument

Chronic rash Y N _____
 Changing growth Y N _____
 Skin cancer Y N _____
 Breast cancer Y N _____

FAMILY HISTORY

Did/does someone in your family have:

Glaucoma Y N _____
 Diabetes Y N _____
 Cancer Y N _____
 Heart attack Y N _____
 Stroke Y N _____
 Other Y N _____

PAST HISTORY (complete each line)

List all medications you take None _____
 List all eye medications you take None _____
 List all medical illnesses and injuries None/ SEE ABOVE _____
 List any surgeries you have had None _____
 Do you have any allergies to prescription or OTC medications Y /N List _____

Gastrointestinal

Ulcers Y N _____
 Gastritis Y N _____

Genitourinary

Kidney stones Y N _____
 Prostate enlargement Y N _____

Neurological

Stroke Y N _____
 TIA Y N _____
 Headaches Y N _____
 Psychiatric (depression) Y N _____

Endocrine

Thyroid disease Y N _____
 Pituitary Y N _____
 Diabetes Y N _____
 Menstrual abnormalities Y N _____

Hematologic/Lymphatic

Bleeding disorder Y N _____
 Lymphoma/leukemia Y N _____

Allergic/Immunologic

Asthma Y N _____
 Seasonal allergies Y N _____

Other symptoms not noted above Y N _____

SOCIAL HISTORY

Do you work? (list job) Y N _____
 Do you drink alcohol? Y N _____
 If yes, how many glasses a day _____
 Do you smoke? Y N Quit
 If yes, how many packs a day and for how long

_____/_____/_____
PHYSICIAN SIGNATURE **DATE** **TECHNICIAN**