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

Today's Date____/____/_____

Last Name_____, First Name_____ MI_____

Primary Insuredôs Name_____ Primary Insuredôs Date of Birth___/____/____

Street Address_____

City_____ State_____ Zip Code_____ Age_____

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

Date of Birth_____ SSN_____ Sex M F

Marital Status S M D W Employer_____

Primary Language Spoken_____

Medical Insurance_____ID#_____

Primary Insuredôs 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 or co-insurance, 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. 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. I also understand and agree that if my account goes delinquent more than sixty days, interest will accrue at the rate of 1.5% per month on the unpaid balance. If my unpaid account continues unpaid and is given to a collection company, I agree to pay for collection readying fees, collection fees and/ or legal fees.

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.

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, Dr. Aarup Kubal, Dr. Jesse Pelletier and Dr. Andres Sarraga** 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 ñYESò, 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 _____

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
_____
_____

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 _____

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
_____

PAST HISTORY (complete each line)

List all medications (incl. dosage and schedule) 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 _____

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

Please make sure both sides are COMPLETED IN FULL