Alexander Eye Associates
Alexander Optical

261 Alexander Street • Rochester, NY • 14607

Patient Information

Name: _____ Miss Ms. Mr. Rev. Mrs. Sr. Dr. Other:_____
First Name Middle Initial Last Name

Address: _____ Date of Birth: _____

City/State/Zip: _____ Sex: ☐ Male ☐ Female

Phone: H) _____ W) _____ C) _____

E-mail: _____ Employer / Occupation: _____

Spouse / Partner: _____

Contact Person

Name: _____ E-mail: _____
First Name Middle Initial Last Name
(Guardian - if patient is under age 18 yrs of age)

Address: _____ Relationship to patient: _____

City/State/Zip: _____

Phone: H) _____ W) _____ C) _____

Insurance

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Primary Insurance: _____ Subscriber ID: _____

Secondary Insurance: _____ Subscriber ID: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Specify):_____

Financial Assignment

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable

Acknowledgement of Notice of Privacy Practices

I acknowledge that I received a copy of Notice of Privacy Practices from Dr.'s Caito & Sugnet - Alexander Eye Associates - Alexander Optical

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices

☐ **Yes, I have read or had explained to me by this office the NPP & wish to continue my care under said terms.**

☐ **No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.**

☐ **The NPP could not be read due to the emergent nature of the care needed.**

_____ _____
Signature agreeing to all above terms Date

Name: _____ DOB: _____

Vision and Medical History

When (approx.) was your **last eye exam**? _____

Please list all eye conditions you have experienced: _____

Primary Care MD: _____

Do you have any of the following:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension (high blood pressure)
- ☐ Migraines/headaches
- ☐ Multiple Sclerosis (MS)
- ☐ Thyroid Disease
- ☐ Amblyopia
- ☐ Eye Dryness
- ☐ Floaters or Spots
- ☐ I experience regular headaches
- ☐ Loss of vision
- ☐ Sandy or gritty feeling in eyes
- ☐ Strabismus (crossed eyes)
- ☐ Tired eyes
- ☐ Watery eyes
- ☐ Wear glasses
- ☐ Wear contact lenses

☐ Other Medical Conditions/Surgeries:

_____

_____

☐ Allergies: _____

Please list all prescription and non-prescription drugs you are currently taking:

_____

_____

Family History

Do any Family members (blood relatives) have or had:

- ☐ Blindness
- ☐ Diabetes
- ☐ Eye turn / Lazy Eye
- ☐ Glaucoma
- ☐ Hypertension (high blood pressure)
- ☐ Macular Degeneration
- ☐ Retinal Detachment

Referral Information

How did you find us?

☐ Referred by PCP: _____

☐ Referred by a current patient: _____

☐ Internet search ☐ Visited our Website ☐ Found us on social media ☐ Phone Book

Questions ?

Do you have a question? Concerns? We want to know!