QUEENS EYE ASSOCIATES

PATIENT INTAKE FORM

☐ Male ☐ Female ☐ Married ☐ Single ☐ Partner ☐ Widowed ☐ Divorced

Name: _____

Address:_____ **Apt. or floor:**_____

City:_____ **State:**_____ **Zip:**_____

Home phone:_____ **Work:**_____ **Cell:**_____

E-mail address:_____

Birth date (month / day / year):_____ **Age:**_____ **Soc. Sec. number:**_____

Employer:_____ **Occupation:**_____

Family physician:_____ **Physician phone:**_____

Emergency contact:_____ **Emergency phone:**_____

How did you hear about QEA?_____

Are you interested in Laser Vision Correction? ☐ Yes ☐ No **Date of last eye exam:**_____

I authorize the staff or doctors of Queens Eye Associates to leave voicemail messages for me, email me, or text message me regarding product status notifications (e.g. glasses ready to be picked up), appointment reminders, test results, diagnoses and treatments.

Voicemail: ☐ Yes ☐ No **Email:** ☐ Yes ☐ No **Text message:** ☐ Yes ☐ No

INSURANCE INFORMATION

Major medical:_____ **Member ID number:**_____

Name of policy holder:_____

Do you have a vision benefit? ☐ Yes ☐ No

If yes, which one? ☐ Davis ☐ VSP ☐ OPTUM Spectera ☐ EyeMed

Vision plan ID number:_____

Insurance Authorization and assignment of benefits: I hereby authorize Queens Eye Associates to furnish insurance carriers any information concerning my condition and treatments, and I hereby assign to Queens Eye Associates all payments for services rendered to my dependants or myself. I understand that I am responsible for the amount not covered by my insurance.

Date:_____ **Signature:**_____