New Patient Form

Dr. Mark Sorrentino, O.D.

General Information

First Name: _____ Last Name: _____

Nickname/Preferred Name: _____ Pronunciation: _____

Date of Birth: _____

Primary Care *Physician* Name: _____

Primary Care *Office* Name: _____

Pharmacy *Name*: _____

Pharmacy *Address*: _____

How do you prefer to receive your bills?: ☐ Mail ☐ Text Message

How did you hear about our office? _____

Contact Information

Mobile Phone: _____ Home Phone: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name/Relation: _____

Emergency Contact Phone #: _____

Vision History

Do you currently wear prescription glasses?: ☐ Yes ☐ No

Do you currently wear prescription contact lenses?: ☐ Yes ☐ No

What Brand?: _____

Do you currently own Polarized sunglasses?: ☐ Yes ☐ No

Do you have any of the following eye conditions?:

- ☐ Glaucoma
- ☐ Diabetes/Diabetic Retinopathy
- ☐ Keratoconus
- ☐ Dry Eye
- ☐ Macular Degeneration
- ☐ Retinal Defects
- ☐ Strabismus
- ☐ Exotropia/Outward Turn
- ☐ Esotropia/Inward Turn
- ☐ Ingrown Eyelashes
- ☐ Total Vision Loss/Scarring
- ☐ None of the Above

Does anyone in your immediate family have any of the following conditions? (circle all family members that apply):

- ☐ Cataracts: Mother Father Sister Brother Son Daughter
- ☐ Glaucoma: Mother Father Sister Brother Son Daughter
- ☐ Retinal Disease: Mother Father Sister Brother Son Daughter
- ☐ Blindness: Mother Father Sister Brother Son Daughter
- ☐ Macular Degeneration: Mother Father Sister Brother Son Daughter
- ☐ Crossed Eyes: Mother Father Sister Brother Son Daughter
- ☐ Myopia/Near-Sightedness: Mother Father Sister Brother Son Daughter
- ☐ None of the Above

Do you experience any of the following?:

- ☐ Redness
- ☐ Floaters/Black Spots
- ☐ Eyestrain
- ☐ Itching
- ☐ Crescent Shadows
- ☐ Double Vision
- ☐ Burning
- ☐ Flashes of Light
- ☐ Headaches
- ☐ Tearing
- ☐ Rainbow Auras
- ☐ Blurry Vision
- ☐ Light Sensitivity
- ☐ Difficulty Tracking Letters
- ☐ None of the Above

Have you had any of the following procedures?:

- ☐ Lasik Vision Correction
- ☐ Cataract Removal Surgery
- ☐ Retinal Laser Photocoagulation
- ☐ Post-Cataract YAG Laser Capsulotomy
- ☐ Eye Muscle Correction Surgery
- ☐ Enucleation/Eyeball Removal
- ☐ None of the Above

What could be improved with your vision?:

- ☐ Distance Vision
- ☐ Computer/Intermediate Vision
- ☐ Near Vision
- ☐ Night Vision
- ☐ Glare
- ☐ Clarity
- ☐ Muscle Control
- ☐ Nothing/I Love My Vision!

Medical History

Do you have any of the following Medical Conditions?

- ☐ Cancer
- ☐ Hearing Loss
- ☐ Chronic Sinusitis
- ☐ Dry Mouth
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Chronic Migraines
- ☐ Stroke
- ☐ Hypertension/High Blood Pressure
- ☐ Heart Disease
- ☐ Hypothyroidism/Under-Active Thyroid
- ☐ Vascular Disease
- ☐ Hyperthyroidism/Over-Active Thyroid
- ☐ Graves' Disease
- ☐ Smoke Inhalation
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Chron's Disease
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Acid Reflux
- ☐ Kidney Disease
- ☐ Pregnancy
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ STD
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Lupus
- ☐ Sjogren's Disease
- ☐ Anemia
- ☐ Leukemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ ADD/ADHD
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Hypercholesterolemia/High Cholesterol

Please list any conditions not mentioned above:

_____

_____

_____

_____

Does anyone in your immediate family have any of the following conditions? (circle all family members that apply):

- ☐ Hypertension/High Blood Pressure: Mother Father Sister Brother Son Daughter
- ☐ Hypercholesterolemia/High Cholesterol: Mother Father Sister Brother Son Daughter
- ☐ Hyperthyroidism/Over-Active Thyroid: Mother Father Sister Brother Son Daughter
- ☐ Hypothyroidism/Under-Active Thyroid: Mother Father Sister Brother Son Daughter
- ☐ Heart Disease: Mother Father Sister Brother Son Daughter
- ☐ Cancer: Mother Father Sister Brother Son Daughter
- ☐ None of the Above

Please list any Medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

Please list any Allergies:

_____

_____

_____

_____

Do you drink Alcohol?: ☐ Yes ☐ No

How Often?: ☐ Rare ☐ Moderate ☐ Severe

Do you smoke Tobacco?: ☐ Yes ☐ No

How Often?: ☐ Some Days ☐ Every Day

Have you smoked Tobacco in the past?: ☐ Yes ☐ No

Consent to Office Policies

Consent to Financial Responsibility:

As a courtesy, we will attempt to verify and file your claim with your vision care plan or insurance carrier. However, **we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance, allowance overages and any non-covered services as determined by your contract with your carrier**. Final liability to the patient is only made after the carrier reviews the claim and determines eligibility and coverage. This process may take up to 1 year. **If the insurance provided at the time of the appointment is incorrect, we may not be able to correct the claim to the proper insurance, and you will be responsible for the full payment of the exam and materials.**

If your insurance company denies any part of your claim, you will be responsible for the remaining balance. **Verification is only an explanation of benefits based upon information that we received from your insurance carrier. We cannot guarantee it is accurate and it is not a guarantee of payment**. Please contact your insurance carrier directly if you wish to confirm your individual benefits. If your vision care plan or health insurance company determines that a particular service is not covered under your plan, your insurer will deny payment for that service. **If your insurance company denies payment, you will be personally and fully responsible for payment**. If your health insurance company does make payment for services, you will be responsible for any deductible, co-payment/co-insurance, allowance overages and any non-covered services that apply.

Payment Policy:

Insurance co-pays, co-insurance and deductibles must be paid at the time of service. Balances over 120 days old may be subject to **interest at an annual rate of 24%** (2% per month). A **50% deposit is required for glasses orders**. A **100% deposit is required for contact lens orders**. **Optomap photos are required and cost $29** if not covered by insurance. **Contact lens fitting fees range from $60-$120** depending on insurance, experience, and script.

Hold Policy:

For the convenience of our patients, we allow billing to be **postponed for up to 30 days** to allow full usage of insurance benefits. **Any unused benefits may be lost when the exam is billed.**

No-Show Fees (Advanced Beneficiary Notice):

Any missed appointments or cancellations within 24 hours may be subject to a **$50 fine.** Exceptions may be made for medical or familial crises. Patients may cancel or reschedule appointments with at least 24 hours' notice at no cost.

Consent to the Release of Medical Information:

The release of medical information is authorized to any entity that may be liable for your coverage to assist in the reimbursement of benefits that the patient is entitled to, and to other health care providers that may be assisting in your care and treatment.

NAME (PRINT) **SIGNATURE** **DATE**

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