PHYSICIAN EYECARE OF NY

Tel: 212-689-2020 Fax: 212-689-2954

IN ORDER TO PROPERLY SERVE YOU WE NEED THE FOLLOWING INFORMATION. ALL INFORMATION IS KEPT CONFIDENTIAL.

PLEASE PRINT CLEARLY

Dr/Mr/Mrs/Ms/Miss: _____ Date of Birth: _____/_____/_____

Address: _____Apt #: ____ City: _____ State: _____Zip: _____

Phone Number Where You Can BEST Be Reached: (____) _____ Circle: Mobile Home Work

Additional Phone Number: (____) _____ M H W [PLEASE INCLUDE BEST CONTACT

Sex: ☐ **M** ☐ **F** **Marital Status** ☐ **M** ☐ **W** ☐ **S** ☐ **D** **Hispanic/Latino** ☐ **Y** ☐ **N**

Race: ☐ **White** ☐ **Black** ☐ **Alaskan/ Hawaiian Native** ☐ **Asian/Indian** ☐ **Pacific Islander** ☐ **Declined**

Surgical History

Year	Type of Operation

Family History

Mother		**Grandfather**	
Father		**Grandmother**	
Sister			
Brother			

Glasses/Contacts: ☐ **Yes** ☐ **No** ***if you wear contacts - Years Worn: _____ Maximum Wearing Time: _____ hrs***

Primary Complaint(s):

☐ **Dry Eyes** ☐ **Itchiness** ☐ **Blurry Vision** ☐ **Irritation** ☐ **Eye Pain** ☐ **Eye Redness** ☐ **Burning**

Medicine	Dosage	Allergy	Severity (Mild, Moderate, Severe)

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Name of Pharmacy: _____
Phone: (____) _____

PLEASE READ AND SIGN:

PEONY will file claims for primary and secondary insurance. Co-payments and charges for non covered services due in full at time of service. **Many insurance policies consider a refraction to be a non-covered service. A refraction is the test necessary to determine if you have had a change in your vision and might need a new prescription. If you choose to have a refraction done you are responsible for payment at the time of service. Our fee is $30. If you have a vision plan, the proper receipt will be given to you so that you may be reimbursed by them. <u>WE DO NO ACCEPT OR SUBMIT TO VISION PLANS</u>. It is your responsibility to be aware of and follow your insurance restrictions and/or guidelines. If your insurance requires a referral you are responsible for obtaining that referral.**

We require 24 hours notice for appointment cancellations or you will be billed a copay amount. Full payment of deductibles, coinsurances and other non-covered services are due within <u>30 days</u> of insurance processing. If you require a referral and are seen without it or do not have it at the time of visit you must provide credit card information. If the referral is not received by the close of the business day you will be charged the FULL amount for the visit the following morning.

"**The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I also authorize PEONY or my insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance."**

Signature _____ ***Date*** _____

Robert Latkany, MD Evelyn Icasiano, MD