NEW PATIENT INFORMATION

[ ] MR. [ ] MRS. [ ] MS. [ ] MALE [ ] FEMALE

NAME ________________________________ DATE ______________

ADDRESS ____
STREET
____
CITY/TOWN STATE ZIP

DATE OF BIRTH ________________________ AGE ______________

TELEPHONE # HOME ____________ WORK ____________ CELL ____________

EMAIL ____

RACE: [ ] African American [ ] Asian [ ] Hispanic/Latino [ ] White [ ] Other __________

PREFERRED LANGUAGE ____________________________________

PREFERRED METHOD OF CONTACT: [ ] E-Mail [ ] Postal Mail [ ] Telephone

PRIVATE MEDICAL DOCTOR ____________________________________

ADDRESS ____________________________ TELEPHONE ______________

REFERRED BY ____

PARENT, SPOUSE OR FINANCIALLY RESPONSIBLE PARTY ____________________

CHIEF CONCERN FOR TODAY'S VISIT ____________________________

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INSURANCE INFORMATION

MEDICARE #________________ SOCIAL SECURITY #________________

INSURANCE COMPANY ________________

SUBSCRIBER / I.D. #________________

PRIMARY INSURED'S NAME (IF NOT SELF) ________________

PRIMARY INSURED'S DATE OF BIRTH ________________

OCCUPATION ________________

EMPLOYER ________________

EMPLOYER ADDRESS ________________

MEDICAL HISTORY

DO YOU NOW, OR HAVE YOU EVER, WORN GLASSES? YES [ ] NO [ ]

DO YOU HAVE ANY FAMILY HISTORY OF GLAUCOMA? YES [ ] NO [ ]

DO YOU HAVE ANY FAMILY HISTORY OF CATARACTS? YES [ ] NO [ ]

DO YOU HAVE ANY FAMILY HISTORY OF BLINDNESS? YES [ ] NO [ ]

WERE YOUR EYES CROSSED AS A CHILD? YES [ ] NO [ ]

HAVE YOU EVER HAD AN EYE INJURY OR OPERATION? YES [ ] NO [ ]

IF YES, WHEN? ________________

DO YOU HAVE HIGH BLOOD PRESSURE? YES [ ] NO [ ]

DO YOU HAVE ANY KIDNEY PROBLEMS? YES [ ] NO [ ]

DO YOU HAVE DIABETES? YES [ ] NO [ ]

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES [ ] NO [ ]

IF YES, PLEASE LIST________________

DO YOU SMOKE? YES [ ] NO [ ] IF YES, HOW OFTEN?_______ QUIT DATE _________

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES [ ] NO [ ]
IF YES, PLEASE LIST

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****IF COVERED UNDER MEDICARE SKIP TO THE MEDICARE SECTION BELOW****

Copayments are due at the time of visit. It is your responsibility to understand any deductible or co-insurance that may apply under your policy. We will not bill you more than the allowed amount, as determined by your plan. You will receive a bill for charges determined to be patient responsibility.

I authorize the use of "On File" to be used on health insurance claim forms and electronic submissions. I authorize the release of any medical or other information necessary to process my insurance claim(s). This Signature On File is valid until revoked by me. I authorize payment of benefits to Dr. James Talbot, New Canaan Ophthalmology LLC.

Patient or Parent Signature ________________________________ Date ____________

FOR MEDICARE BENEFICIARIES ONLY :

Copayments are due at the time of visit. It is your responsibility to understand any deductible or co-insurance that may apply under your policy. We will not bill you more than the allowed amount, as determined by your plan. You will receive a bill for charges determined to be patient responsibility.

I authorize the use of "On File" to be used on health insurance claim forms and electronic submissions. I authorize the release of any medical or other information necessary to process my insurance claim(s). This Signature On File is valid until revoked by me. I authorize payment of benefits to Dr. James Talbot, New Canaan Ophthalmology LLC.

Patient ____ Date ____________

I authorize the use of "On File" to be used on MEDIGAP and Supplemental Policy health insurance claim forms and electronic submissions. I authorize the release of any medical or other information necessary to process my insurance claim(s). This Signature On File is valid until revoked by me. I authorize payment of benefits to Dr. James Talbot, New Canaan Ophthalmology LLC.

Patient ____ Date ____________

If signed by a representative:
Name: ____
Address: ____
Relationship: ____
Reason the patient cannot sign: _____________________________________