PATIENT INFORMATION **APT DATE:**

Name:		Social Security #:		Gender:
Date of Birth:	Age:	Please Circle: Single Married Widowed Divorced		
Billing Address:	City:	State:	Zip Code:	
Street Address:	City:	State:	Zip Code:	
Home #:	Cell #:	Email:		
Employer:	Occupation**:**	Work #:	Ext.	

Why did you choose Dr Sokol? _____

If the patient is a minor, the following must be completed:

Guardian's Name: _____ Relationship to Patient: _____

Address _____ Guardian's Phone **#** _____

All patients and / or responsible parties please complete the following:

Primary Insurance:		Secondary Insurance:	
Policyholder name:		Policyholder name:	
Relationship to Insured:		Relationship to Insured:	
Policy Number:		Policy Number:	
Group :	Insured DOB**:**	Group :	Insured DOB:
Insured Employer:		Insured Employer:	

In case of emergency, who should be notified? _____Phone #: _____

Statement of Financial Responsibility

- I accept financial responsibility for my account. I understand that if I have medical insurance, the insurance company may pay only a portion of the total charges, and that I will pay the portion not paid by the insurance company. I agree to pay for claims that are not paid in full by my insurance company within 90 days.
- If I do not have medical insurance, or if a co-payment or other charges are due, I understand that payment is required at the time services are rendered.
- I agree that, if payment is not made at time services are rendered, I will pay interest on any outstanding balance at the maximum rate provided by law until my account is paid in full. I agree to pay any and all additional fees associated with the need to enforce collection through a collection agency or through legal action.
- I authorize Connecticut Eye Specialists, LLC to release any medical or other information to third parties necessary to process payment. I request payment of government benefits either to myself or to Connecticut Eye Specialists, LLC.

Signature: _____ Date: _____

Notice of Privacy Practice

I acknowledge receipt of the "Provider's Notice of Privacy Practices"

Signature: _____ Date: _____

Please complete if Patient is under 18

In case of my absence, I hereby give permission to Connecticut Eye Specialists, LLC for treatment as they deem necessary to my child.

Signature: _____ Date: _____

Name: Date:

What is the purpose of your visit today? **(Please circle)**…..… Regular eye checkup Redness Itching

Irritation Poor Vision Headaches Tearing Other: _____

Which eye is bothering you? ..... Right Left Both When did it start? _____

How often does it happen? _____ How bad is it? .....Mild Moderate Severe

How long does it last? ..... Seconds Minutes Hours Days Constant Other

OCULAR HISTORY

Cataract……..Yes No Glaucoma…… Yes No Other: _____

Have you had surgery on your eyes? .....Yes No Have you had laser on your eyes? .....Yes No

Are you taking any eye drops or medicine for the eyes? ..... Yes No
Please list: _____

Do you wear glasses? .....Yes No contact lenses?.....Yes No Do you have a lazy/crossed eye?....Yes No

How long since your last visit to an eye doctor? _____

MEDICAL HISTORY

Primary Care Physician: _____

Are you pregnant? .....Yes No

Do you take any **pills** or m**edicine**? ..... Yes No
Please list: _____

Are you **allergic** to any medicine? …..... Yes No
Please list: _____

Have you ever had any **major surgery**? ..... Yes No
Please list: _____

Is there anything else we need to know about your health?
Please list: _____

Fever	Yes	No	Ulcers	Yes	No	Seizures	Yes	No
Weight loss	Yes	No	Liver trouble/ Hep C	Yes	No	Diabetes	Yes	No
Unusual fatigue	Yes	No	Kidney or bladder	Yes	No	Thyroid trouble	Yes	No
Heart trouble	Yes	No	Prostate problems	Yes	No	Bleeding tendency	Yes	No
High blood pressure	Yes	No	Muscles or joints	Yes	No	Transfusions	Yes	No
Circulation problems	Yes	No	Arthritis	Yes	No	HIV/Aids	Yes	No
High cholesterol	Yes	No	Skin disorders	Yes	No	Seasonal allergies	Yes	No
Sinus trouble	Yes	No	Nervous disorders	Yes	No	Cancer	Yes	No
Deafness	Yes	No	Stroke	Yes	No			
Breathing / asthma	Yes	No	Migraines	Yes	No	Other: _____		

Do you **drive**? ..... Yes No Do you **smoke**? …….No……..Occasionally……...1 pack……..more
Do you drink **alcohol**? .....Yes No……..Occasionally…….1 per day……more

FAMILY HISTORY (If Yes, who?)

Eye Disease	No	Yes	_____	Diabetes	No	Yes _____
Blindness	No	Yes	_____	Other	_____	