Sound Vision Care, Inc. –

Date: _____ **ID:** _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: _____

Last Name: _____ **First**: _____ **MI**: _____

Home Phone: _____ **Cell phone**: _____ **Primary contact #:** ☐ **Home** ☐ **Cell**

Mailing Address: _____

City: _____ **State**: _____ **Zip Code**: _____ SS# _____

Date of birth: ____/____/____ **Age**: _____ **Height**: _____ **Weight**: _____ **Sex**: ☐ M ☐ F

Race: ☐ African/African American ☐ Asian/Asian American ☐ Caucasian/Euro-American ☐ Other

Ethnicity: ☐ Native American/Native Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Hispanic/Latino ☐ Other

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Student ☐ Disabled ☐ Other

Occupation: _____ **Hobbies:** _____

Student: ☐ Yes ☐ No Grade: _____ If a minor, parent/guardian name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

To access your medical records, please provide an E-mail: _____

Family Physician: _____ Town: _____

Pharmacy: _____ Town: _____

Do you use tobacco? ☐ Yes ☐ No **Do you drink alcohol**? ☐ Yes ☐ No **Do you use recreational drugs**? ☐ Yes ☐ No

Do you have any medical conditions? ☐ Yes ☐ No if yes please list: _____

Do you take medications? ☐ Yes ☐ No if yes, please list: _____

Do you have any allergies to medications? ☐ Yes ☐ No if yes please list medications: _____

Have you had any surgeries? ☐ Yes ☐ No if yes please list: _____

Have you had cataract surgery, or any eye surgery? ☐ Yes ☐ No if yes please list: _____

If female: Are you pregnant? ☐ Yes ☐ No **Are you Nursing**? ☐ Yes ☐ No

Do any of the following apply to your eyes/vision: List any problems with your vision: _____

Y	N		Y	N		Y	N	
☐	☐	Contact Lens wearer	☐	☐	Double Vision	☐	☐	Sunlight sensitivity
☐	☐	Blurry Vision	☐	☐	Dryness of Eyes	☐	☐	Flashes of light
☐	☐	Crossed/Lazy Eye	☐	☐	Tearing Eyes	☐	☐	Floaters

What is the reason for your visit today? _____

Who may we thank for referring you to our office? _____

For your medical records only, we need to keep a photo of each patient on file. Please sign below to give permission for us to take a photo to link to your medical record.

Patient Signature: _____ **Patient printed name:** _____

Continued on back…

Sound Vision Care, Inc.

Riverhead
887 Old Country Rd, Suite K-L
(631)727-2858 | (631)727-2866 f

Southold
44210 Rte 48, Suite 1, Po Box 463
(631)765-3092 | (631)765-3046 f

Southampton
1601 County Rd 39, Suite 5
(631)283-0220 | (631)283-0299 f

Coram
592 Mill Rd, Suite B
(631) 732-0822 | (631) 732-00718 f

East Setauket
23 Technology Drive, Suite 5
(631) 675-6909 | (631) 675-6910 f

Jeffrey S. Williams Sr., OD
Comprehensive Optometry
Contact Lenses

Vincent Coltellino Jr., OD
Comprehensive Optometry
Contact Lenses

Cynthia Zara, OD
Comprehensive Optometry
Contact Lenses

Jeffrey S. Williams Jr., OD Dipl., ABO
Board Certified Optometrist
Comprehensive Optometry
Specialty Contact Lenses
Disease Diagnosis & Management

Monika Murawska, OD
Comprehensive Optometry
Contact Lenses

Payal Thakkar, OD
Comprehensive Optometry
Contact Lenses

Cynthia Wiener, OD
Comprehensive Optometry
Contact Lenses

patient name_____ date_____ ID#:_____

Individuals Responsibility for Non-Covered Services
In consideration of services rendered by providers at Sound Vision Care Inc. to the undersigned patient, the undersigned promise(s) to pay providers at Sound Vision Care any co-payment, co-insurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided. _____
initial

Assignment of Benefit Proceeds
I hereby assign to providers at Sound Vision Care Inc. all monies and/or benefits to which I am entitled from my insurance/HMO/third party payer, government agencies, or those who are financially liable for my medical care.

_____ _____
signature of patient date

Authorization to Release Records
I hereby authorize providers at Sound Vision Care to release to my insurer/HMO/third-party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by paragraph 1 above, which are not medically necessary or improperly billed.

_____ _____
signature of patient date