Patient Information (Please Print) **ADS #** _____

Name _____ SS#_____
Last First Middle

Home Address: _____
Street City State Zip

Home Phone _____ Cell Phone _____

Birthdate _____ Age _____ Sex _____

Marital Status _____ Spouse's Name _____

Occupation _____ Employer _____

Work Address _____ Work Phone_____

Family Doctor _____ Phone _____

Address: _____

Referred By: _____

Insurance Policyholder Information (Please give receptionist your insurance ID cards)

Full Name _____ Birthdate _____

Social Security # _____ Relationship _____

Billing Address (if different from home address) _____

Workman's Compensation Insurance Information

Insurance Company _____ Claim #_____
Employer Name _____ Employer Contact Person_____
Employer Address _____ Phone_____

****Authorization – Please read and sign****

I authorize Dr. Tsakrios to furnish information to insurance carriers concerning my illness, accident and/or treatments. I irrevocably assign to Dr. Tsakrios all payments for medical services rendered to me or to my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. It is my responsibility to understand my insurance coverage and obtain the proper authorizations and/or referrals if applicable prior to the examination. If insurance payments are denied because proper referrals were not obtained then I understand that I will be held liable for the services rendered. I will be financially responsible for any interest and collection charges on delinquent accounts (90 days overdue).

Signature _____ Date _____

Comprehensive Patient History

Name _____ **Date** _____

Review of Systems

Do you have?	YES	NO
Decreased vision	☐	☐
Floaters in your vision	☐	☐
Flashes of Light	☐	☐
Poor color vision	☐	☐
Poor depth perception	☐	☐
Abnormal sensitivity to light	☐	☐
Halos around lights	☐	☐
Problems with glare	☐	☐
Red Eye	☐	☐
Eye which bulges out	☐	☐
Eye discomfort	☐	☐
Eye dryness	☐	☐
Eye itching	☐	☐
Pressure in or behind eye	☐	☐
Tearing of eyes	☐	☐
Discharge	☐	☐
Crusting or red eyelids	☐	☐
Double vision	☐	☐
Headaches from eyestrain	☐	☐
Jagged lines in vision	☐	☐
Fluctuating vision	☐	☐
Blurred vision spells	☐	☐
Abnormal pupil	☐	☐

Past Medical History

Have you had?	YES	NO
Eye Surgery	☐	☐
Eye Injury	☐	☐
Serious Eye Infection	☐	☐
Lazy Eye	☐	☐
Lazy Eyelid	☐	☐
Dry Eyes	☐	☐
Corneal Disease	☐	☐
Glaucoma	☐	☐
Cataract	☐	☐
Retinal Disorder	☐	☐
Eye Tumor	☐	☐
In or out turning eye	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Lung Disease	☐	☐
Neurological Disease	☐	☐
Thyroid Disease	☐	☐
Migraine	☐	☐
Lupus	☐	☐
Asthma	☐	☐

Other illness(es): _____

Family History of:	YES	NO
Cataracts	☐	☐
Glaucoma	☐	☐
Diabetes	☐	☐
Macular Degeneration	☐	☐
Blindness (any cause)	☐	☐
Retinal Detachment	☐	☐
Other eye disorders	☐	☐

Social History	YES	NO
Do you use a computer often?	☐	☐
Difficulty reading?	☐	☐
Difficulty driving due to poor vision?	☐	☐
Difficulty with arms-length vision?	☐	☐
When was your last eye exam?	☐	☐
Do you wear glasses?	☐	☐

If Yes: Distance ☐ Reading ☐ Bifocal ☐
Progressive (Varilux) ☐ Trifocal ☐ Half ☐

Present Medications	Dosage	Freq.
_____	_____	_____
_____	_____	_____

Do you wear contacts? ☐ Yes ☐ No

If Yes: Soft ☐ Gas Perm ☐ Toric ☐
Disposable ☐ Extended Wear ☐

List any allergies to medications, if any:

_____

_____

Are you interested in surgery to correct myopia or astigmatism? ☐ Yes ☐ No

CHARLES TSAKRIOS, JR., M.D.

89 North Maple Avenue, 3rd Floor
Ridgewood, NJ 07450
(201) 445-1991

Privacy Notice Authorization

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Charles Tsakrios Jr. M.D. PA with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

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REFRACTION: NON-COVERED SERVICE

A refraction is part of the exam that determines your best corrected vision and whether there is a need for corrective eyeglasses or contact lenses. Medicare and most medical insurance companies **do not** cover the cost of a refraction.

Our office fee for refractions and contact lenses is collected **in addition** to any co-payment.

Refraction …… $50.00

New Soft Contact Lens Fit…… $175.00
Annual Contact Lens Refit……$60.00
Contact Lens Refit into Toric or Multi-focal lens……$85.00

If you would like a contact lens fitting **and** refraction for glasses, the refraction is ***50% off ($25)*** in addition to the cost of the fitting.

I acknowledge and accept full financial responsibility for the cost of this service and understand that any copayment, coinsurance or deductible I may have are separate from and not included in this fee.

Patient Name _____ Date _____

Signature _____