PROFESSIONAL OPTOMETRY/ ST. PAULS VISION CENTER

Dr. Ann K. Lieberman
Dr. Nathan A. Lieberman
WELCOME TO OUR OFFICE!

PLEASE PRINT

Patient Name: _____ Date: _____
Address: _____ Date of birth:_____
City:_____State:_____Zip:_____ Social Sec #:_____
Person responsible for payment:_____ Home phone:_____
Employed by:_____ Work phone: _____
Referred by: _____ Cell phone: _____
Gender: Male:_____Female:_____ Can you receive text:Yes____or No____
Marital Status:_____ Email:_____
Reason for visit:_____

HEALTH HISTORY

Check all that apply :

____Diabetes ____Skin disorder ____Neurological disease
____High Blood Pressure ____Stomach problems ____Thyroid Condition
____Heart Problems ____Blood disorder ____Fever/weight loss
____Arthritis ____Allergy/immunological ____Genitourinary/Kidney
____Asthma/Lung ____Psychiatric ____Ears/Nose/Throat
____Smoke ____Alcohol

OCULAR HISTORY

____Eye injury ____Floaters or spots ____Flashing lights
____Eye surgery ____Headache ____Cataracts
____Glaucoma ____Macular degeneration ____Lazy/turned eye

FAMILY HISTORY

____Glaucoma ____Macular degeneration ____Retinal detachment
____Blindness ____Lazy/turned eye

Family Doctor:_____
Medications:_____
Medication Allergies:_____

We request payment in full when services are rendered. Please make us aware of all health insurance and/or vision insurance that you have.

Method of payment: Cash ____Check ____Visa/MC ____Medicaid _____Medicare_____
Other insurance_____

All Insurance: I give my permission for Dr. Lieberman to:1)release to the Social Security Administration or other insurance carriers, information concerning my insurance claim, 2)file my insurance claim with Medicare or an insurance company and assign the claim benefits paid to Dr. Lieberman and 3)contact any medical professional whom my doctor(s) deem necessary for the furtherance of my medical care. I understand that:1)my consent is good for all services for the remainder of my life, and 2)I am responsible for any unpaid balance not paid by my insurance company. I certify that:1)the information I have given is correct , and 2)I have complete authority to execute this document on behalf of myself or patient.

Signature:_____Date:_____