David W. Ferris, O.D., D.O.S.
Stephen M. Montaquila, O.D., F.A.A.O.
Georgia Patsiopoulos, O.D., F.A.A.O.

Welcome To Our Office!

Thank you for choosing our practice for your eye care needs. Please take a few minutes to fill out this form as completely as you can. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

( ) MR ( ) MRS ( ) MS ( ) MISS ( ) ________

FULL LEGAL NAME: ____ DATE OF BIRTH: _______________

ADDRESS: ___________________________________ CITY: ________________ STATE: _______ ZIP: ________

HOME PHONE: _________________WORK PHONE: ___________________ OTHER______________________

EMPLOYER: ____ OCCUPATION: ____________________________

SSN: ________________________ REFERRED BY: ____

DO YOU PREFER TO RECEIVE CALLS AT: ( ) HOME ( ) WORK ( ) OTHER

ARE YOU: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) MINOR

IF MINOR NAME OF PARENT/GUARDIAN: ____

EMPLOYMENT: ( ) FULL TIME ( ) PART TIME ( ) RETIRED ( ) NOT EMPLOYED

STUDENT ( ) FULL TIME ( ) PART TIME

NAME OF EMPLOYER OR SCHOOL: ____

SPOUSE NAME: _____________________________________ SPOUSE DATE OF BIRTH: _________________

INSURANCE: ______________________________________NAME OF INSURED:__________________________

SECOND INSURANCE:______________________________ NAME OF INSURED__________________________

VISION INSURANCE:________________________________NAME OF INSURED:__________________________

LAST 4 DIGITS OF SS# OF INSURED__________________DOB OF INSURED:___________________________

EMERGENCY CONTACT:___________________________________ RELATIONSHIP:______________________

EMERGENCY CONTACT PHONE:____________________________

PURPOSE OF VISIT: _________________________________ DATE OF LAST EYE EXAM:________________

DO YOU WEAR: ( ) GLASSES ( ) CONTACT LENSES TYPE: _______________________________________

DO YOU HAVE ANY HISTORY OF: ( ) HIGH BLOOD PRESSURE ( ) HEART DISEASE ( ) DIABETES

( ) ALLERGIES ( ) GLAUCOMA ( ) EYE INJURY ( ) EYE SURGERY ( ) DRY EYES ( ) FLOATERS

IS THERE FAMILY HISTORY OF ABOVE: ____

DO YOU: ( ) SMOKE ( ) DRINK MORE THAN 2 OZ ALCOHOL / DAY ( ) EXERCISE REGULARLY

HAVE YOU USED DRUGS, OTHER THAN PRESCRIBED, IN THE PAST: ( ) YES ( ) NO

PLEASE COMPLETE THE NEXT PAGE AND BRING THESE FORMS AND A PICTURE ID AND ALL INSURANCE CARDS TO THE RECEPTIONIST.

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PATIENT NAME:____ DOB ____________________________

FULL NAME OF PRIMARY CARE PHYSICIAN: ____

DATE OF LAST VISIT: ___________________

OTHER PHYSICIANS THAT YOU ARE CURRENTLY SEEING (1) ______________________________________

(2) __________________________ (3) _____________________________ (4) ___________________________

LIST ANY MEDICATIONS THAT YOU ARE TAKING:____

____

____

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ____

IMPORTANT NOTICE REGARDING HEATLH INSURANCE BILLING:

I request that payment of the authorized health insurance benefits be made to me or on my behalf to West Bay Eye Associates for any services furnished by the doctors and staff employed here. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges, whether or not paid by the insurance, for services rendered on my behalf. The patient's portion is due at the time services are rendered.

Once West Bay Eye Associates has obtained my one-time authorization, they may submit any later insurance claims on either an assigned or non-assigned basis, without obtaining any additional signature from me. In submitting claims, they should indicate on the patient's signature line "Signature on File."

Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. There will be a $25 charge for any missed/cancelled appointments without giving 24 hour notice to the office.

______________________________ ________________________________ ___________________________

Patient or guardian signature | Patient or guardian name (print) | Date

ALL PATIENT RECORDS ARE KEPT CONFIDENTIAL IN ACCORDANCE WITH WEST BAY EYE ASSOCIATES NOTICE OF PRIVACY POLICIES