BERRY MILNER AND SARGENT

Patient Name_____ **DOB** _____**Age**____

Marital Status: Married Divorce Single Widow SSN _____ **Sex: M F**

Mailing Address_____ **City** _____

Email _____**State**_____ **Zip**_____

Cell Phone _____ **Daytime Phone**_____

Language Spoken_____ **Ethnicity**: Hispanic/Not Hispanic (circle one)

Emergency Contact _____ **Phone**_____

Primary Physician_____ **Phone**_____

Referred by _____**Phone**_____

Describe the reason for your visit: _____

Primary Insurance: _____

Policy holder Name _____DOB_____SSN_____

Secondary Insurance: _____

Policy holder Name_____ DOB_____SSN_____

Copay, Deductibles, and Coinsurance are due at the time of service

Consent to Treatment

I hereby authorize the physicians and staff of Berry, Milner and Sargent to perform procedures necessary to assess, diagnose and treat my condition as necessary.

Authorization and Assignment of Benefits

I hereby authorize Berry, Milner and Sargent to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign Berry, Milner and Uhr LLP all payments otherwise payable to me for services provided by Berry, Milner and Sargent.
I understand that I am responsible for all charges incurred for my care.

Patient Signature_____Date_____

Guarantor Name (Please Print) _____

Guarantor Signature_____Date_____

(See other side)

PAST MEDICAL HISTORY:

Please Answer Each Question.
List any medical condition that you have had or currently have: (i.e. diabetes, blood pressure, arthritis, etc.)

List any eye diseases that you have (i.e. glaucoma, cataract, lazy eye, retinal problems)

List any surgeries that you have had by date and reason.

List any allergies to drugs or food.

List all medications that you are currently taking including eye drops.

_____

_____

_____

FAMILY HISTORY:
List eye diseases that run in your family (i.e. glaucoma, macular degeneration)

SOCIAL HISTORY:
Do you now or have you smoked, consumed alcohol, abused drugs? How much and when? Does anyone live with you?

REVIEW OF SYSTEMS:

DO you currently have any other medical problems? Please circle Y (yes) or N (no) for each area. Explain any yes answers.

Y N Constitutional symptoms: Chronic fever, unexplained weight loss/gain, fatigue
Y N Ear/Nose/Throat problem
Y N Heart problems
Y N Respiratory problems
Y N Urinary problems
Y N Gastrointestinal problems
Y N Hematological problems
Y N Skin problems
Y N Musculoskeletal problems
Y N Neurological problems
Y N Psychiatric problems