LISA S. BUNIN, M.D.

WELCOME

PATIENT INFORMATION

DATE: __________________

Thank you, for choosing our practice for your eye care and or cosmetic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name: ____ Date of Birth: _________Age: _________
First MI Last
Address: ________________________ City: ______________ State: ______ Zip: _________
Social Security # ______________________
Home Phone #: _________________________ Work Phone #: _______________________
Cell Phone #: ______________________ E-mail: __________________________________
Do you prefer to receive calls at: Home ☐ Work ☐ Cell Text & E-Mail
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Primary Language: _________________ Preferred Pharmacy: ___________________________ Phone: _____________
☐ Minor: Full time student: if so where? ____
Your or your parent's employer: __________________________Occupation: ___________________________
Employer's Address: _______________________________ City: _________________________
State: _________ Zip: _________ Phone ____________________

SPOUSE INFORMATION
Spouse or parent's name: ________________________ Date of Birth: ______________ Social Security # ____________
Employer: ____________________________________Work phone: _________________
Employer's Address: _____________________________ City: ____________________State: _______ Zip: _________
Emergency contact: __________________________ Relationship: _________________
Phone #: __________________

Family Physician: __________________________________ M.D. , D.O. Phone #: ____________________
First name Last name
Address: _________________________________ City: ___________________ State: _______

Whom may we thank for referring you to us? ____

RESPONSIBLE PARTY (If not same as patient)
Name: _________________________________ Address: ____
Date of Birth: ____________ Social Security #: ______________________________
Phone #: Home –Work - Cell ______________________________
Relationship to patient: _________________

Do you give consent to disclose health information to your spouse? ☐ yes ☐ no _______initial
May we leave a message on your answering machine or cell phone? yes☐ no _______initial

Please indicate any individual(s) allowed access to your medical information. (Please note due to hippa regulations we may not discuss anything pertaining to your appointments without your signed consent. ☐ No-one _____ initial

Please be sure to initial
1) ___________________________________ relationship________________ initial _______phone #________________
2) ___________________________________ relationship________________ initial _______phone #________________

Referring Physician: ____

INSURANCE INFORMATION

Lisa S. Bunin, M.D.

Name of Insurance Company: ____________________________________
Insurance Company Address: ____________________________________
City: __________________________ State: _______
Policy Number: _________________________ Group Number: _______________
Copay: Y N $ _________ Deductible: Y N $_____________
Subscriber: ___________________ Date of Birth: ______ Relationship to patient: _________
Effective date of policy: _________ Type of plan: ____________
Name of Employer: ___________________________ Date Employed: ___________
Address: ____________________________ City: __________________ State: ________ Zip: _______

DO YOU HAVE ADDITIONAL INSURANCE? Y N IF YES PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Company: ____
Insurance Company Address: ____ City: _________________
State: ____________
Policy Number: ______________________ Group Number: _______________
Copay: Y N $ __________ Deductible: Y N $_____________
Subscriber: ___________________ Date of Birth: _________ Relationship to patient: ____________
Effective date of policy: ___________ Type of plan: ______________

ASSIGNMENT OF BENEFITS

____ **X** I assign the benefits from my insurance carrier(s) to Lisa S. Bunin, M.D. for the medical/surgical benefits I am entitled to.

____ **X** I understand that I am financially responsible for any charges not covered by this authorization.

____ **X** I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

Patient or Responsible Party
Signature____Date____________________

I HAVE RECEIVED AND READ A COPY OF THE FINANCIAL POLICY, ASSIGNMENT, AND RELEASE OF INFORMATION PARAGRAPHS THAT THAT APPLIES TO ME.

PLEASE INITIAL AND DATE RECEIPT OF FINANCIAL POLICY

____________ DATE: ________________

Person Signing on Behalf of Patient ____
Please Print Name ____
Relationship to Patient ____
Reason Patient Cannot Sign ______________________________________

Revision 04/11/2017

Lisa S. Bunin, M.D.

Health History Information Form **Date:** ______________

Patient Name: ________________________________ Date of Birth: ________________ Age: _______
Preferred Pharmacy:________________ Pharmacy Location:__________________ Phone: ____________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY, THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Person filling out this form: ____
Relationship to patient: ___________________ **Signature**: ______________________________________

1. **PAST MEDICAL HISTORY** – Have you ever had the following: ___**Patient denies any PMH**

___Alzheimer's ___ Depression ___ Hepatitis ___ Lupus ___ Sarcoidosis
___Anemia ___ Diabetes Type 1 ___ Herpes Zoster __ Meniere's ___Seizures
___Asthma ___Diabetes Type 2 ____High Cholesterol ___ Mental Health Problems ___ Sickle Cell Anemia
___Atrial Fibrillation ___Fibromyalgia ____Hypertension (HBP) ___ Migraines ___Sinus
___Bell's Palsy ___Gallbladder ____ Kidney Problems ___ Parkinson's ___ Sleep Apnea
___Cancer ___Gastric Ulcer ____Liver Problems ____ Reflux ___ Stroke
___Crohn's ___Heart Disease ____ Lung Problems ___ Rheumatoid Arthritis ___ Thyroid problem
___ Tuberculosis

Other: ____

2. **EYE CONDITIONS** – Have you ever had any of the following: ____**Patient denies any conditions**

____ Cataracts ____Eye Surgery ____Sensitivity to light ____ Eye infection or disease
____ Glaucoma ____Eye Injury ____ Floaters or spots _____ Double vision
___ Mac Degen. ____ Medical Treatment ____ Poor distance vision ____ Eye strain
____ Retinal Prob. ____Severe Pain ____ Poor near vision ____ Eyes burn, itch or water

Other eye conditions: ____

3. **PAST SURGICAL HISTORY** – Have you ever had the following: ____ **Patient denies any past surgeries**

_____ Cancer Surgery _____ Organ Transplant _____ Eye Surgery/Lid Surgery
_____ Gastric Bypass _____ Sinus Surgery _____ Plastic Surgery
_____ Heart Surgery _____Thyroid Surgery _____ Lasik or Refractive Surgery
_____Hysterectomy _____Vascular Surgery _____ Laser Eye Surgery

Other: ____

Please check any of the following conditions that apply to you:
_____Frequent headaches _____Drug allergies _____Pregnant _____Sinus trouble
_____Have you given birth in the last 6 months?
Other: ____

CURRENT MEDICATIONS: (Please include dose and how many times per day taken.)
____**Patient denies taking any medications**

__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________
__________________ __________________ __________________ __________________

Please list any vitamins that you are taking: ____
Are you allergic to any medication? ____Yes _____No If yes, what? _________________________
Allergic to: ____Latex Gloves ______ Contrast dye/Iodine _____ No Known Drug Allergies

Reason for today's exam: ____
Date of last exam: _____________ Name of previous eye doctor: ________________________________

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4. **FAMILY HISTORY** – Does anyone in your family have a history of the following?

________ Blindness
________ Cataract
________ Cornea Transplant
________ Diabetes Type 1
________ Diabetes Type 2
________ Glaucoma
________ Heart Condition

________ Hypertension
________ Keratoconus
________ Macular Degeneration
________ Allergies
________ Cold sores
________ Retinal Detachment
________ Turned or Lazy Eye
________ Asthma

5. SOCIAL HISTORY

Tobacco: ☐ **Yes** ☐ **Minimal** ☐ **(__- packs/day/wk. x ____ys)** ☐ **quit** ☐ **never**

Alcohol: ☐ **Daily** ☐ **Less than once per week** ☐ **More than once per week**

Do you wear glasses? ___Yes ___No Date of Prescription____________________________________
When do you wear glasses?
___All the time ___Work/ Safety ___Reading ___Computer work ___Distance tasks only

Have you worn contacts? ___Yes ___No Date of Prescription_____________________________________
If yes, what type?
___Soft ___Extended wear ___Gas Permeable ___Bifocal ___Tinted
___Astigmatic ___Disposable ___Unsure

Do you work at a computer? __Yes __No If yes, How many hours per day?_________________________

What hobbies or sports do you participate in? ____

How did you hear about our practice?
___Physician ___Friend or Family Member ___A Seminar ___Insurance Company
___Internet ___Yellow Pages ___Advertisement/ Article

If you were referred by one of our patients, please share his or her name so we may thank them.
Patient's name: ____

Are you currently having trouble in any of the following areas? Explain your answers.

	YES	NO	Explanation of Problem
Constitutional Symptoms			
Fever	[ ]	[ ]	____________
Weight Loss	[ ]	[ ]	____________
Other	[ ]	[ ]	____________
Eye			
Loss of vision/Blurred vision	[ ]	[ ]	____________
Distorted vision (halos)	[ ]	[ ]	____________
Loss of side vision	[ ]	[ ]	____________
Double vision	[ ]	[ ]	____________
Dryness	[ ]	[ ]	____________
Mucous discharge	[ ]	[ ]	____________
Redness	[ ]	[ ]	____________
Sandy or gritty feeling	[ ]	[ ]	____________
Itching	[ ]	[ ]	____________
Burning	[ ]	[ ]	____________
Foreign body sensation	[ ]	[ ]	____________
Excess tearing/watering	[ ]	[ ]	____________
Occasional tearing	[ ]	[ ]	____________
Glare/Light sensitivity	[ ]	[ ]	____________
Eye pain or soreness	[ ]	[ ]	____________
Chronic infection of eye or lids	[ ]	[ ]	____________
Sties, chalazia	[ ]	[ ]	____________
Fluctuating visual acuity	[ ]	[ ]	____________
Flashes of light	[ ]	[ ]	____________
Floaters in vision	[ ]	[ ]	____________
Glasses: type, how used, age of Rx	[ ]	[ ]	____________
Contact Lens use, type, age of Rx	[ ]	[ ]	____________
Video display terminal use	[ ]	[ ]	____________
Ears, Nose, Mouth, Throat, Body			
Sinus congestion	[ ]	[ ]	____________
Cold symptoms	[ ]	[ ]	____________
Dry mouth/throat	[ ]	[ ]	____________
Respiratory (breathing)	[ ]	[ ]	____________

This information is completely confidential but will help us to serve you better.

What are your primary areas of concern? ____

Would you be interested in?
____Laser or Surgical Vision Correction
____Multifocal Intraocular Lenses
____Custom Cataract Surgery

Would you be interested in any of the following cosmetic services?

____Restylane
____AHA and Glycolic Peels
____Collagen Therapy
____Skin Rejuvenation
____Retin-A or Renova
____Microdermabrasion
____Botox Cosmetic
____Acne Treatment
____Chemical Peels
____Laser Resurfacing
____Laser Treatment s
____Avage (tazarotene)
____Skin Care Advice
____Skin Care Products
____Birthmarks
____Other, please specify________________________________
____Sunscreen Advice
____Removing Leg Veins
____Facial and Hair Treatments
____Hair Removal
____Spider Vein Treatments
____Removing Facial Veins
____Liver or Age Spot Treatments

Have you ever had fillers? (___Restalyne, ___Radiesse, ___Juvederm, ___Other___________)
Have you ever had Botox? ____yes ____no
Have you ever had Lasers? ____yes ____no if yes for what? ______________________________________
Have you ever had cosmetic surgery? ____yes ____no if yes for what? ____________________________
Were you pleased with the outcome? ____yes ____no if not, Why? ________________________________

If our office held a seminar for patients to learn more about certain cosmetic procedures, would you be interested in attending? ____