Dawn P. Rush, MD

Renee Richards, MD * Nechama Mina Shoshani, MD * Jill Chafitz, OD

Pediatric Ophthalmology & Adult Strabismus

2649 Strang Boulevard, Suite 203 * Yorktown Heights * New York * 10598

Patient's Last Name_____ First Name_____ MI____

Date of Birth_____ Age_____ Sex: F M Race:_____ Language_____

Address_____ Apt #___ City_____ State____ Zip_____

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Emergency Contact:_____ Relationship_____ Phone:_____

Primary Care Physician_____ Referring Physician_____

Pharmacy:_____ Location:_____ Tel #_____

Email:_____

Please list all family members seen in this office:

Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F

Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F

Primary Medical Insurance: **Does your insurance require a referral? Y N**

Policy Holder Name_____ DOB_____ Relationship_____

Insurance Carrier_____ Policy #_____ Group #_____

Employer:_____ Occupation_____ Co-Pay Amount_____

Secondary Medical Insurance: **Does your insurance require a referral? Y N**

Policy Holder Name_____ DOB_____ Relationship_____

Insurance Carrier_____ Policy #_____ Group #_____

Employer:_____ Occupation_____ Co-Pay Amount_____

Pediatric Only:

Mother's Name_____ Address_____ Phone_____

Father's Name_____ Address_____ Phone_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I have recieved **Dawn P. Rush, MD PLLC notice of privacy practice.**

*Responsible Party Signature:*_____ *Date:*_____

Medical History Questionnaire

Please print clearly and use the back of this page if you need more space

Today's date:_____
Name :_____
Your age:_____
Who is your medical doctor?_____
What is the main reason for your visit today?_____
_____

Do you have any of these eye symptoms?
O Blurred distance vision O Glare, halos around lights
O Blurred reading vision O Itching or burning eyes
O Constant double vision O Eye mattering or tearing
O Flashing lights or floaters O Foreign body sensation
O Red eyes O Dry eye O Eye pain

Do you have any allergies to any medications?
O None known O Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Which eye medications do you currently take?
O None O Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which other medications do you currently take?
O None O Aspirin on a daily basis?

Medication Name:	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?
O Cataract O Serious eye injury
O Glaucoma O Iritis / uveitis
O Macular degeneration O Lazy eye
O Wore eye patch as a child O Retinal detachment
Other:_____
_____

Do you have any allergies? N Y_____
_____

Have you ever had any of these conditions?
O None
O Stroke O Dizziness O High blood pressure
O Arthritis O Allergies O Heart disease
O Diabetes O AIDS, HIV O Lung disease
O Cancer O Anemia O Thyroid disease
O Headaches O Other: _____
_____

Have members of your family had any eye diseases?
(This would be your father, mother, sister, brother, grandparents)
O Glaucoma O Diabetic eye disease or diabetes
O Cataract O Crossed eyes O Macular degeneration
O Iritis/uveitis O Blindness O Retinal detachment
O Poor vision O Other:_____
_____

Please list any eye operations you have had:
O None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any other operations you have had:
O None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illness have caused a hospital stay?
_____
_____

If you have glaucoma:
In what year was the diagnosis first made?_____
Month and year of your last visual field test?_____
Name of your previous ophthalmologist?_____

Social History:
Smoker? Y N # of packs per day?_____
# of packs per week?_____
Ex-smoker? Y N

Would you like to wear contact lenses?
O Yes O Not interested at this time

What was the approximate date of your last eye Examination:_____

Physician Signature: _____

Dawn P. Rush, MD, PLLC

Renee Richards, MD Nechama Mina Shoshani, MD Jill Chafitz, OD

Acknowledgment

I _____acknowledge that I am financially responsible for non-covered services.

I hereby authorize the office of **Dawn P. Rush, MD PLLC** to keep my signature on file and to charge my Credit card as indicated below:

Balance of charges not paid by insurance to include:
Copays, coinsurance, deductibles, refraction charges $45.00, visual field exams, fundus photography, supply of contact lenses etc...

Any administrative charges for no show appointments $75.00 during the week
$100.00 on weekends

I assign my insurance benefits to the provider listed above. I understand that this form will be shredded after the document has been secured in our system. If I need to cancel the authorization for this credit card I will give written consent to the healthcare provider.

Patient Name:_____
Cardholder Name:_____
Cardholder Billing Address:_____
City_____State_____Zip_____

Please check one ( ) MasterCard ( ) Visa ( ) Discover

_____-_____-_____-_____Expiration Date ____/____
Account Number MO YR

Cardholder Signature: _____

Date:_____

Our office policy requires a credit card to be on file for services

If you choose not to fill out this form please state why.

_____
_____
_____