



TODAY'S DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP CODE)

(HOME PHONE) \_\_\_\_\_ (WORK PHONE) \_\_\_\_\_

(CELLULAR/PAGER) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

MARITAL STATUS: (please check) S  M  W  D  GENDER:  MALE  FEMALE

OCCUPATION: \_\_\_\_\_ PATIENT EMPLOYER: \_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE? PLEASE FILL IN BELOW**

DOCTOR: \_\_\_\_\_ PATIENT: \_\_\_\_\_ OTHER: \_\_\_\_\_

**IN CASE OF EMERGENCY:**

RELATIONSHIP TO PATIENT: \_\_\_\_\_ TELEPHONE NUMBER: ( ) \_\_\_\_\_

**PRIMARY INSURANCE CARRIER:**

POLICY # \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBER NAME (if not self) \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Subscriber D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

POLICY # \_\_\_\_\_ GROUP# \_\_\_\_\_

SUBSCRIBER NAME (if not self) \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Subscriber D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



HAVE YOU HAD OR CURRENTLY HAVE?

|  |                          |                          |
|--|--------------------------|--------------------------|
| Cataracts.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Detached Retina.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry Eyes.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Injury.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Floaters.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal Diabetes.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU WEAR <u>CONTACT LENSES</u> ?..... | <input type="checkbox"/> | <input type="checkbox"/> |

LIST ANY MEDICATIONS YOU ARE USING: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, the undersigned fully consent to the consultation. I also acknowledge responsibility for the payment of all services. Unless I have arranged otherwise, I will pay for the services at my first office visit.

I understand there will be a \$50.00 charge for missed appointments that are not cancelled at least 24 hours in advance.

Additionally, I realize any non-covered services, co-payments and/or deductibles not paid by the insurance plan will be my responsibility.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SO THAT WE MAY HONOR YOUR PRIVACY, PLEASE ANSWER THE FOLLOWING QUESTIONS

|   |                              |                             |
|---|------------------------------|-----------------------------|
| May we telephone or leave a message on your home answering machine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| May we leave a message at your place of employment?                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| May we discuss your medical condition with a family member?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

\*If yes, name of family member: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

FOR PATIENTS WITH INSURANCE COVERAGE ONLY:

I request that payment of authorized Medicare, Medigap, or other insurance company benefits be made to Eric R. Mandel, M.D., P.C., on my behalf, for any services furnished to me by the provider. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents and the Centers for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_