**Behavioral Optometry** • **Vision Therapy and Rehabilitation**
**Samantha Slotnick, OD, FAAO, FCOVD**
495 Central Park Ave • Suite 301, Scarsdale, NY 10583 • (914) 874-1177 • www.DrSlotnick.com

**WELCOME to the office of Dr. Samantha Slotnick.** All information will be kept confidential**.**

**Adult Intake Form**

TODAY'S DATE: _____
Mrs. / Mr. / Sr. / Rev. / PhD / MD / MS

□ Ins card(s) copied front/back □ ABN signed?
□ Records Release filed? Y/N □ Referral Needed? Y/N

Patient's Last Name: _____First Name _____M.I.___

Sex: M / F Age:_____ Birthdate: _____/_____/_____ *MARITAL STATUS* M / S / D / DP / W

Address: _____ Home # ( ) _____
□ Permission to txt appt confirm'n?

City_____ State_____ Zip_____ Cell # ( ) _____

Email: _____ Best Contact # __H /__W / ___Cell / ____E-mail

Occupation _____

Employer _____ Work # ( ) _____

Work Address_____

**Spouse/Partner's Name** _____ Cell # ( ) _____

Email _____ Other #_____ Best Contact # __H /__W/ __Cell/ __E-mail

*In case of emergency notify:*
Name _____ Phone # ( ) _____ Relationship _____

***New patients:*** **Who referred you?** _____

***Do you exhibit any of these symptoms?***

| | | |
|---|---|---|
| ☐ **Headaches** | ☐ **Clumsiness** | ☐ **Flashing lights** |
| ☐ **Eye Fatigue** | ☐ **Difficulty judging distances** | ☐ **Floating spots** |
| ☐ **Avoidance of reading** | ☐ **Poor depth perception** | ☐ **Glare** |
| ☐ **Loss of place when reading** | ☐ **Balance problems** | ☐ **Excessive tearing** |
| ☐ **Poor reading comprehension** | ☐ **Limited use of peripheral vision** | ☐ **Excessive burning or redness** |
| **Blurred vision:** | ☐ **Double vision** | ☐ **Itching eyes/ eyelids** |
| ☐ **With distance viewing** | | |
| ☐ **With near work/ on the computer** | ☐ **Difficulty with nighttime driving** | ☐ **Other** _____ |

***Do you…?***
☐ **wear contact lenses** ☐ **own a backup pair of glasses** ☐ **have sunglasses** ☐**own office/computer glasses**

☐**Have any hobbies/ pastimes? (sports/ music/ art/ needlepoint/ sewing/ models/ collections, etc.)** _____

_____

**REASON FOR TODAY'S VISIT** _____

_____

Date of your last Eye Examination: _____ Doctor's name/ location:_____

Have you ever had eye surgery? _____

Interested in contact lenses? **Y N** Interested in refractive surgery (e.g., LASIK)? **Y N** Hours on the computer/ day? _____

Current medications / vitamins supplements (please include OTC) _____

_____

Is there a **Family History** of (circle all applicable): **Allergies** to meds? **Y N** _____

High blood pressure / Diabetes / Glaucoma / Macular Degeneration / Lazy eye / Eye turn

Comments: _____

Physician's Name_____ Phone #: _____

Address_____

ALL INSURANCE CARDS AND VISION COVERAGE MUST BE PRESENTED BEFORE SERVICES ARE RENDERED. PROOF OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT BY THE INSURANCE COMPANY. PLEASE BE AWARE THAT:
1) MEDICAL INSURANCE DOES NOT COVER NON-MEDICALLY RELATED VISION EVALUATIONS.
2) VISION PLANS DO NOT COVER NON-ROUTINE OCULAR HEALTH (MEDICAL) SERVICES.

## Medical insurance Information

Insurance Company_____
Member or Primary Insured's I .D. #_____ Group number _____
Primary Insured's name: _____ DOB_____
Relationship to Patient: _____

### RELEASE OF INFORMATION AND INSURANCE FILING

I request that payment of authorized insurance be made to Dr. Samantha Slotnick for any services rendered. I authorize any holder of medical information about me, to release to HCF and its agents any information needed to determine these benefits payable for related services. I also understand there may be procedures that are not covered by my insurance and I am responsible for payment, including but not limited to refraction. I understand that payment in full is expected when services are rendered and materials dispensed.

SIGNATURE _____ Date _____

### CANCELLATION POLICY:

**Your extended appointment time with the doctor is reserved expressly for you. There is a $50 Cancellation Fee for all appointments cancelled/rescheduled within 48 hours of the appointed time. If you need to modify, cancel or reschedule your appointment, please be sure to make your request via email no less than 48 hours in advance: Jane@DrSlotnick.com**

**Please INITIAL HERE to acknowledge consent: X_____**

HIPAA privacy acknowledgement - I was given and read, and understand my privacy rights under the HIPAA laws.

Signature_____Date_____