Brian Ludwig, OD & Eric Ludwig, OD
Long Island Optometry Care, PLLC
Setauket, NY 11733

Patient's Information

Today's Date ___/___/___ Email ______________________ Employed / Unemployed / Student
Patient's Name ______________________ Married / Single DOB ___/___/___
Address ______________________
City ______________________ State ____________ Zip____________
Phone number ______________________ Social Sec. #______________________
Occupation ______________________ Place of Employment ______________________
Reason for visit______________________

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Insurance Coverage

Major Medical ______________________ I.D. Number ______________________
Primary Insured Name ______________________ Self / Spouse / Parent DOB ___/___/___
Vision Care Coverage ______________________ I.D. Number ______________________
Last Eye Exam ______________________ By Whom ______________________
Last Physical ______________________ By Whom ______________________

Please check off any condition which you or any of your family members are being treated for:

Relative	Self		Relative	Self	
___	___	Constitutional Symptoms (Fever, weight loss)	___	___	Musculoskeletal
___	___	Eyes	___	___	Integumentary (skin and/or breast)
___	___	Ears, nose, mouth, throat	___	___	Neurological
___	___	Cardiovascular (High Blood Pressure)	___	___	Psychiatric
___	___	Respiratory (Asthma, COPD)	___	___	Endocrine (Diabetes)
___	___	Gastrointestinal	___	___	Hematologic / Lymphatic
___	___	Genitourinary	___	___	Allergic / Immunologic

Have you experienced any of the following conditions with your eyes (Y or N)
Double Vision ___ Loss of Vision ___ Flashing Lights ___ Floating Spots ___ Pain Around The Eyes ___

Describe any eye injuries or surgeries you have had, along with the treatment received.

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Describe any surgeries you have had to treat any health problems.

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Please List any medications you are presently taking (including: birth control and over-the-counter).

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List any allergies you presently have (including: medications, shellfish, seafood and iodine products).

____

I Hereby authorize Long Island Optometry Care, PLLC to furnish to my insurance carrier any information concerning my condition treatments and hereby assign Long Island Optometry Care, PLLC all payments for services rendered to myself or dependents. I undersign that I am responsible for any amount not covered by my insurance.

Signature ______________________ Date ___/___/___

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I received a copy of Long Island Optometry Care, PLLC’s Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient’s Name ____

Signature ____ Date ___/___/___

If you are signing as a person representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________ Print Name ____________________

Source of Authority: ____