

NYLASERGROUP

Harry Koster M.D. P.C.

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COMPREHENSIVE EYE CARE
LASER VISION CORRECTION
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Richmond Hill, NY 11419
Tel. 718. 805-0700

PLEASE PRINT CLEARLY

REFERRED BY: Optical Store Medical Dr. Other-Specify _____

NAME OF OPTICAL STORE _____

PRIMARY MEDICAL DOCTOR _____ Phone#() _____

Patient Last Name: _____ First Name _____

Patient Sex: Male Female Date of Birth: _____

Social Security: _____ Marital Status: Single Married Widowed

Home Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone () _____ E-Mail Address _____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: () _____ Occupation: _____

Insurance Information (FILL OUT ALL INFO)

Name of Primary Insurance: _____

Name of Insured: _____ ID #: _____ Group #: _____

Insured Social Security #: _____ Insured Date of Birth: _____

Name of Secondary Insurance (If Any): _____

Name of Insured: _____ ID #: _____ Group # _____

Insured Social Security #: _____ Insured Date of Birth: _____

Do you currently wear glasses? ___Yes ___No

If Yes: ___all the time ___sometimes ___distance ___reading ___computer

How important is it for you to read or use the computer without glasses?

___Very important ___Important ___Somewhat important ___Not important

Do you drive at night? ___socially ___occasionally ___professionally

If it were possible to go without glasses for most of the time, would you like that?

___Yes ___No

Are you interested in surgery to reduce your need for glasses? ___Yes ___No

Check the following activities you do on a regular basis:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> _ Read newspaper, books | <input type="checkbox"/> _ Read medicine bottles | <input type="checkbox"/> _ Needlepoint/sew | <input type="checkbox"/> _ Computer/Internet |
| <input type="checkbox"/> _ Drive daytime | <input type="checkbox"/> _ Drive nighttime | <input type="checkbox"/> _ Shop | <input type="checkbox"/> _ Golf |
| <input type="checkbox"/> _ Tennis | <input type="checkbox"/> _ Hunt or Fish | <input type="checkbox"/> _ Paint / Artist | <input type="checkbox"/> _ Cook |
| <input type="checkbox"/> _ Musician | <input type="checkbox"/> _ Play Cards / Dominos | <input type="checkbox"/> _ Bicycling, Roller blades, etc | |
| <input type="checkbox"/> _ Photography | <input type="checkbox"/> _ Spectator Sports | <input type="checkbox"/> _ Movie theatre | <input type="checkbox"/> _ Other _____ |

Underline the above activities that you would like to see *without glasses if possible*

Have you ever worn contacts? ___ Yes ___ No

Are you interested in learning more about laser vision correction (LASIK)? ___Yes ___ No

Patient or Authorized Signature:

I authorize the release of any medical information necessary to process this claim and request payment of benefits to Harry Koster, M.D. PC. I understand that I am financially responsible for all fees and will be billed for any balance, deductible and co-payment which my insurance does not cover.

If I am a member of a managed care program, I am aware that it is my responsibility to provide Dr. Koster with a referral form. If Dr. Koster is unable to collect from my insurance company because of my failure to provide him with a referral in a timely manner, I agree that I will be responsible to pay for these services personally.

I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature

Date

CONFIDENTIAL