**Stanley J. Berke, M.D., FACS**
**1600 Stewart Avenue, Suite 306**
**Westbury, NY 11590**
**516-794-2020 Fax: 516-794-2029**

# Patient Demographic Form

(***Must be updated yearly or if any Patient information changes***)

Name Last: _____ First: _____ Middle: _____Date of Birth: _____

Social Security #: _____ Gender: M ☐ F ☐ Marital Status: S ☐ M ☐ W ☐ D ☐

Race: (Please Check Which Applies) ☐Caucasian ☐African-American ☐Asian ☐Other:_____

Ethnicity: ☐ Hispanic/Latino ☐ Non- Hispanic/Latino
Preferred Language: ☐ English ☐Spanish ☐ French ☐ Other: _____

Mailing Address: _____ City _____ State: _____Zip:_____

Home Phone: _____Cell Phone:_____Email Address:_____

Occupation: _____Employer: _____Work Phone: _____

Preferred Method of Contact: ☐Home ☐ Cell ☐ Work ☐ Email ☐ Other: _____

Spouse Name: _____ DOB:_____ SS#_____

Address:_____ Phone:#. _____

Employer: _____ Work Phone: _____

Emergency Contact Name/Relationship:_____Phone:_____

Please list individual(s) we are authorized to speak with regarding your care:

_____

Referred By: _____ Relationship_____ Phone:_____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy:_____Address:_____ Phone:_____

**INSURANCE INFORMATION** - ***PLEASE PROVIDE INSURANCE CARD TO BE COPIED***

**PRIMARY**
Insurance Company:_____ Policy Holder/ Relationship:_____
Policy Holder DOB: _____ Policy Holder SS#:_____

**SECONDARY**
Insurance Company:_____ Policy Holder/ Relationship:_____
Policy Holder DOB: _____ Policy Holder SS#:_____

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**Patient History Sheet**

NAME: _____ DOB:_____ Date:_____

**Reason for Today's Visit: or (Circle one)**

- **Glaucoma**
- **Cataracts**
- **Diabetic Eye Exam**
- **Decrease Reading Vision**
- **Decreased Distance Vision**
- **Thyroid Eye Exam**
- **Headaches/Eye-Pain**
- **Peripheral Vision Loss**

**Other**:_____
**Date of last Ophthalmic Exam**:_____
**Do You Wear Glasses?** YES or NO. **If Yes** for Distance or Near? Glasses for other:_____

**Review of Systems Check Yes or No and Circle which Applies**

| | YES | NO |
|---|---|---|
| **GENENERAL/CONSTITUTIONAL** (fever, heat stroke, weight loss/gain. unusually tired, etc.) | | |
| **CARDIOVASCULAR** (blood pressure, racing pulse, etc.) | | |
| **EARS, NOSE, MOUTH, THROAT (**chronic sinusitis, hearing loss, ringing in ears, etc.) | | |
| **EYES** (poor vision, eye pain, tearing, redness, etc.) | | |
| **RESPIRATORY** (congestion, wheezing, shortness of breath, etc.) | | |
| **GASTROINTESTINAL (**stomach upset. diarrhea, constipation, hernia, ulcers, etc.) | | |
| **GENITAL, KIDNEY, BLADDER** (painful or frequent urination. impotence, jaundice. etc.) | | |
| **INTEGUMENTARY / SKIN** (pimples. warts, rash. etc.) | | |
| **NEUROLOGICAL (**numbness, headache, seizures, paralysis, etc.) | | |
| **PSYCHIATRIC** (anxiety. depression. insomnia, etc.) | | |
| **ENDOCRINE** (diabetes, thyroid, etc) | | |
| **BLOOD / LYMPH** (bleeding, cholesterolemia, anemia, trouble re: blood transfusions, etc.) | | |
| **ALLERGIC / lMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.) | | |
| **FEMALES - Are you pregnant or nursing?** | | |

**Personal and Family History**

| Diseases | Self | Mother/Father | Sister/Brother | Grandparents | Other |
|---|---|---|---|---|---|
| Diabetes | | | | | |
| Hypertension | | | | | |
| Cataracts | | | | | |
| Glaucoma | | | | | |
| Cancer | | | | | |
| Heart Disease | | | | | |
| Asthma | | | | | |
| Thyroid | | | | | |
| Blindness | | | | | |
| Stroke | | | | | |
| Other | | | | | |

Ocular Injuries and Dates (Please indicate Right, Left or Both):_____

Ocular Surgeries and Dates (Please indicate Right, Left or Both):_____

Medical Surgical History: (Please list all surgeries and dates)_____

**Allergies to Medication(s) and Reaction(s):**

| Medication | Reaction | Date of reaction |
|---|---|---|
| | | |
| | | |
| | | |

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# Current Medication List

NAME: _____ DOB:_____ Date:_____

**(Please list all the medications you are currently taking)**

| Current Eye Drops | Eye Used In | Frequency | Start Date (if known) | End Date |
|---|---|---|---|---|
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| Oral Medications | Dose | Frequency | Start Date (if known) | End Date |
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**Please Document if you are taking any blood thinners, such as Coumadin (Warfarin) or Aspirin(Motrin, Ibuprofen). Also Please document if you are taking Flomax (for enlarged prostate) or have taken it in the past.**

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## Release of Medical Information

I authorize Dr. Stanley J. Berke and his staff to release and/or obtain any medical records concerning myself from / to any physician, hospital or agency involved with my care.

I authorize Dr. Stanley J. Berke and his staff, when necessary to submit prescriptions to my Pharmacy – Electronically, by Phone or Fax.

## Assignment of Medical Benefits

I authorize my insurance carrier to assign all medical benefits, if applicable, to Dr. Stanley J. Berke and his staff. I also authorize release of medical information necessary to process all medical insurance claims.

## Payment Policy

Co-payments are to be collected on the day of appointment. We accept cash, check, Credit and Debit Cards. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility / non-payable / non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

If this account is assigned to an attorney for collections and / or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

## I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

**Patient Name (print):_____**

**Patient Signature: _____ Date: _____**

**Witness Name (print):_____**

**Witness Signature: _____ Date: _____**

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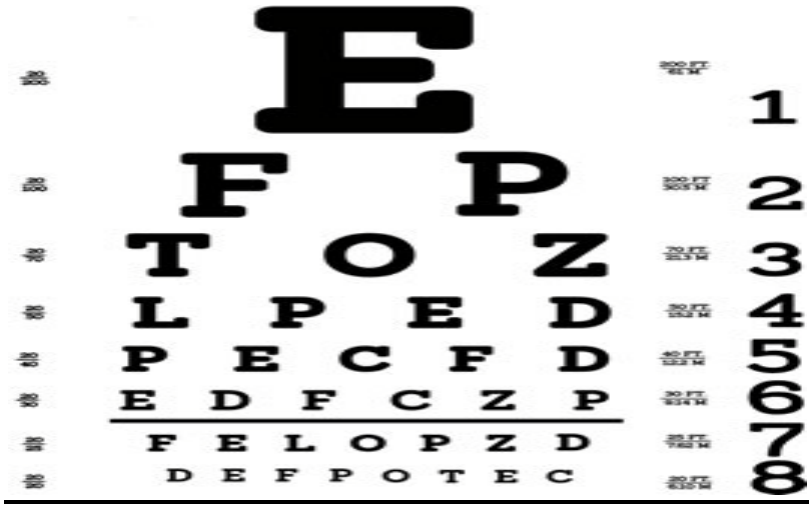
Berke Eye Care
"We are focused on you..."

***SPECIALIZING IN GLAUCOMA AND PREMIUM CATARACT SURGERY***

# Refraction Policy




A Refraction is the process of determining if there is a need for corrective lenses to see clearly. This series of tests determines the eye glass prescription.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations. Medicare requires that we charge separately for that portion of the examination, since it is not a covered service. At times, it is medically necessary to perform a refraction to help determine the cause of visual changes. This is particularly helpful when patients have multiple issues affecting their eyes such as cataract, glaucoma and macular degeneration. Despite being medically necessary, refractions are still not considered a covered service.

If you have a separate vision plan that covers routine or annual eye examinations and / or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

The refraction fee is a separate fee from the eye examination fee and is due at the time of service along with any co-pay or co-insurance required by your insurance plan. Our office fee for a refraction is $50.00.
Should your plan pay us for the refraction, we will reimburse you accordingly.

**Patient Name (print):_____**

**Patient Signature: _____ Date: _____**

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## Appointment No Show and Cancellation Policy

**We understand that there are times when you must miss an appointment due to an emergency or family obligation. However, when you do not show for an appointment or cancel in a timely manner, other patients may be prevented from getting much needed care. In an *effort* to accommodate *as* many patient needs as possible we require a minimum of 24 -hour notice to cancel or reschedule an appointment.**

**In order to help ensure that we are best able to meet as many patient needs as possible, a $50.00 charge will be assessed to patients who do not show for an appointment, or who cancel or reschedule an appointment within 24-hours of the appointment time.**

**Patient Signature: _____ Date: _____**

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Dear Berke Eve Care Patient,

We appreciate your confidence in choosing our office for your medical care. Please take a moment to review our financial policy.

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up with each program's provisions and changes.

- If you are an enrollee of a managed care plan that we are contracted with, you are required to pay the co-payment each time you are seen. The co-payment must be made prior to seeing the doctor.

- Some plans have an annual deductible, you must meet your deductible before your insurance carrier will cover your expenses. In the event that there is a balance due after your insurance carrier has paid its portion, we will bill you. If you do not understand why you owe a balance, please do not hesitate to contact our office at 516-794-2020.

- If your insurance requires a referral from your primary care physician, you must have the referral with you in order to be seen. If you arrive with no referral, you will be asked to reschedule. It is your responsibility to acquire the referral from your primary care physician.

Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or use a facility that is outside of the program, you will be responsible for the appropriate fees.

Our staff is dedicated to working with you and your insurance carrier to process your claim. We appreciate your assistance in working with our staff and your insurance carrier.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a manual and a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance papers and records for future reference.

**I have read the above and understand my obligations and acknowledge receipt of this information.**

**Patient Signature: _____ Date: _____**