Dr. howard budner & associates

Patient updates

Welcome back to our office! Please help us serve you best by updating your information. Thank you!
Please Review any filled in portions, correct information where it is incorrect and fill in the remaining information.

Today's Date: _____ **I have reviewed this information and have no changes since last visit**: _____

Patient's Name: _____ Birth Date: ____/____/____

Address: _____

Phone - Cell: (_____)_____ Home: (_____)_____ Work: (_____)_____

Email: _____ Social Security Number: _____/_____/_____

Male / Female Married/Partner Single Separated Divorced Widow

Employer: _____ Job Title: _____ Full Time / Part Time Student

Guarantor's Information (Insurance Plan Member – Parent, Spouse, Guardian):

Name: _____ Birth Date: ____/____/____ SS#: _____/____/_____

Address: _____

Phone: (_____)_____ Email: _____

Insurance Information (Please list & provide cards to staff, if new): **No change in insurance since last visit:** _____

Medical Insurance Provider: _____ ID #: _____

Secondary Medical Provider: _____ ID#: _____

Vision Insurance Provider: _____ ID#: _____

Secondary Vision Provider: _____ ID#: _____

REASON FOR YOUR VISIT TODAY (Please circle all that apply):

Annual/Routine Exam Annual/Eyeglass Prescription Annual/Contact Lens Fitting Medical Problem/Medical Follow-up

Problem w/Distance Vision Problem w/Near Vision Problem w/Computer Vision Dry Eyes Excessively Watery Eyes

Flashes Floaters Decreased Peripheral Vision Problem w/Glare or Light Sensitivity Problem w/ Night Driving

Interested in LASIK Vision Correction Other _____

MEDICAL UPDATE (Please circle all that apply):

Allergies Cancer Cataracts Diabetes Eye Injuries: (Year_____ What_____) Glaucoma

Headaches/Migraines Heart Problem High Blood Pressure High Cholesterol Immune Disorder Pregnant Nursing

Macular Degeneration LASIK/PRK (Year: _____) Medications: _____

Other _____

I understand that I am responsible for providing the correct medical and/or vision insurance information for this date of service on or before the services are rendered and acknowledge that I will be responsible for any services not covered, for co-pays or co-insurance. I acknowledge that I have been made aware of the HIPPA notice of privacy practices, and that there are additional charges for contact lens services. I understand that you will bill the medical and/or vision plans for services and/or products provided by this office on my behalf whenever appropriate to do so. I understand that my bill today may not be the final amount because my insurance plan must be billed or due to changes that may occur to my material order(s) (such as a change in contact lens brand or type).

Patient: _____ Date: _____

Guarantor: ____ Date: ________________________