Stahl Eye Associates

669216 450 Endo Blvd Garden City, NY 11530 516-832-8000

4:30 pm

WELCOME! Please complete this form and return it to the receptionist so we may prepare your chart.

Personal Information

Last Name: Bartolomeo	First Name: Elizabeth	M.I. A	DOB: 10-8-36
SS #: 064-30-0974	Bill To "SAME"	Street Address: 125 East Saint Marks Place	
City: Valley Stream	State: NY	Zip 11580-4437	Home Phone: 516-561-0676
Employer:			Employer Phone:
Today's Date: 9-7-99	Age of Patient: 62	Occupation: home maker	
Name of Nearest Relative: Richard Bartholomeo			Phone: 516-561-0676
Whom may we thank for referring you to us (Name and address): Tom Bartolomeo			

Insurance Information

Medicare #:	Medicaid #:
Is Medicare your secondary payor as a result of TEFRA ? Y (N)	
Are you currently a member of an HMO, HIP or other managed care plan? Y (N)	

Other Insurance # 1

Private Insurance Name: United Healthcare		
Claims Address: P.O. Box 740800 Atlanta, Ga. 30374-0800		
Insured's Name: Richard Bartolomeo	Patient's relationship to Insured: Self Spouse Child Other:	
ID#: 073-28-9487	Group: 136572	Policy #: 0136572

Other Insurance #2

Private Insurance Name:		
Claims Address:		
Insured's Name:	Patient's relationship to Insured: Self Spouse Child Other:	
ID#:	Group:	Policy #:

Payment of benefits directly to the physician

I request that payment of authorized benefits be made directly to Stahl Eye Associates on my behalf for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or agent any information needed to determine these benefits or the benefits payable for related services.

Signature: x Elizabeth Bartholomeo Date: 9-7-99

Please turn over and fill out the other side of this form →

Medical History

Diabetes	(N)	Y	for ____ years; Last blood sugar: ____ taken when? ____			
Asthma	(N)	Y	for ____ years; Well controlled on medication?		N	Y
High Blood Pressure	N	(Y)	for 15 years; Well controlled on medication?		N	(Y)
Glaucoma	(N)	Y	for ____ years; Is there a family history of glaucoma?		N	Y
Heart Attack	(N)	Y	Number of attacks: ____ ; What year was the last one: ____			
Stroke	(N)	Y	Number of strokes: ____ ; What year was the last one: ____			
High Cholesterol	(N)	Y	Arthritis	(N)	Y	
Heart Disease	(N)	Y	Cancer	(N)	Y	
Bronchitis	(N)	Y	Emphysema	(N)	Y	

Other (please list):

Medications

Are you taking medications for your eyes? (N) Y If yes, please list:

Are you taking any other medications? N (Y) If yes, please list:

Norvasc Tab 5 mg - Tenormin Tab 25 mg - Premarin Cream - once a day -

Are you allergic to any medications? (N) Y If yes, please list:

Eye History

How many years ago was your last eye examination: 3 months

Do you wear glasses? N (Y) if yes, for: Distance Reading (Both) How old are they 2 1/2

Do you wear contact lenses? (N) Y if yes: Hard Soft Wearing for ____ years

Have you ever had any surgery performed on your eyes ? N (Y) If yes, please list:

laser

What is the main problem that you are having with your eyes that you are here for today:

Macular Degeneration

Primary Care Physician/Family Doctor

Name: Dr. Perry Gould

Address 173 MINEOLA BLVD
MINEOLA, 11501