Eye Surgeons and Physicians, PC

6080 Jericho Turnpike, Ste. 102
Commack, NY 11725
Phone: 631-486-4742

486 Sunrise Hwy.
West Babylon, NY 11704
Phone: 631-482-1371

Patient Information

Last Name:_____ First:_____ M.I._____

Address:_____

City:_____ State:_____ ZIP:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Alternate Phone: _____

Social Security Number:_____ Date of Birth:_____

Email:_____

Sex: M F *Marital Status*: Married Single Divorced Widow

Alternate Contact:_____ Phone:_____

(May be called for treatment, operational or payment reasons)

Emergency Contact: _____ Phone: _____

Referring Physician:_____ Phone:_____

If this is an injury or accident where did it occur?: _____ **Date:**_____

Primary Care Physician:_____ Phone:_____

Pharmacy name & address _____ Phone:_____

How did you hear about us? ☐ Referring Doctor ☐ Advertisement ☐ Friend

Employer Name:_____ Phone No.:_____

Employer Address:_____

Primary Insurance Information

Primary Insurance Name:_____

Identification Number:_____ Group No.: _____

Primary Policy Holder's Name:_____ Date of Birth: _____

Primary Policy Holder's SS#:_____

Primary Policy Holder's Employer:_____

Relationship to Patient:_____

Secondary Insurance

Secondary Ins. Name:_____ Policy Holder's Name:_____

Identification Number:_____ Policy Holder's Date of Birth:_____

Group Number:_____ Policy Holder's SS#:_____

Secondary Policy Holder's Employer:_____

I request that payment of authorized benefits be made on my behalf to the above provider for services furnished by that physician. I authorized release to the indicated insurance carrier any medical information about me to determine these payments for related services.

Signature _____ Date: _____

R 8/2026

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Date: _____

Patient Name: _____ Date of Birth: _____

EYE HEALTH

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
____	____	Wear Glasses or Contacts
____	____	Decreased Vision
____	____	Blind Spot in Vision
____	____	Poor Side / Night / Color Vision
____	____	Light sensitivity
____	____	Halos around Lights
____	____	Red / Puffy Eyes
____	____	Dry / Itchy Eyes
____	____	Pressure Behind Eyes
____	____	Abnormal Tearing
____	____	Discharge / Crusty Eyes
____	____	Fluctuating / Double Vision
____	____	Floaters / Jagged Lines in Vision
____	____	Flashing Lights
____	____	Past Eye Injury
____	____	Lazy Eye
____	____	Abnormal Pupil
____	____	Corneal Disease / Condition
____	____	Cataract
____	____	Glaucoma
____	____	Retinal Disorder / Condition
____	____	Crossed Eyes as a Child
____	____	Have you had eye surgery? Date?_____ Explain:_____
____	____	Have you had LASIK or laser procedures?Date?_____Explain:_____

MEDICAL HEALTH

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
____	____	Diabetes
____	____	High Blood Pressure
____	____	Arthritis
____	____	Do you have any other medical conditions?
____	____	_____
____	____	Have you been hospitalized or had surgery?
		explain: _____
____	____	Allergies to Food or Medications?
		List: _____
		_____
____	____	Medications including Eye Drops:
		List: _____
		_____
		_____
		_____
____	____	Do any Medical or Eye conditions run in your family? (High Blood Pressure, Diabetes, Cataracts, Glaucoma, Other)
		_____
		_____
____	____	Recreational Drugs? _____
____	____	Alcohol? _____
____	____	Smoke? _____

Reviewed by Physician_____

EYE SURGEONS AND PHYSICIANS, P.C.
RICHARD GOTLIB, M.D.
SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, TREATMENT CONSENT

INSURANCE ASSIGNMENT

I, the undersigned, hereby authorize payment of health insurance benefits that I am entitled to per my benefits contract with my insurer, which are otherwise payable to me, paid to my physician. This authorization will include those medical benefits payable to the physician who rendered care on my behalf.

I hereby authorize payment of all claims filed by the above referenced providers of healthcare services. I hereby authorize the provider of healthcare services to release any health information that may be required by the health insurers. I attest that Eye Surgeons and Physicians, P.C. have been requested to maintain my signature on file for the purposes of filing claims permitted by this assignment.

GUARANTEE OF PAYMENT

I, the undersigned, hereby acknowledge that I am the guarantor on the account(s) established on my behalf and, as such, will be responsible for payment of **all charges or non-covered charges**. I understand that I will be required to make payment in full on the remaining balance when I receive a statement or letter of notice that the balance is due from me.

FEES

I understand there is a fee of $25.00 for any checks returned unpaid by the bank. Eye Surgeons and Physicians, P.C. reserves the right for all future payments by the undersigned to be paid in cash or money order. For all patient balances over 30 days, there is a $5.00 statement processing fee, cumulative per month, on unpaid monies due to the practice. Eye Surgeons and Physicians, P.C. reserves the right to charge $25.00 no-show/cancellation fee for any office related visits and procedures with less than 24hrs. notice.

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

As the provider of healthcare services, we are hereby authorized to release any medical information required in treating you, for payment for services rendered to you. Before we release information to parties other than for treatment, payment of your account or for healthcare operations we will require specific authorization from you. I acknowledge that I have received Eye Surgeons and Physicians, P.C. HIPAA Privacy Notice and understand that this notice also serves as Notice of Privacy Practices of contracted anesthesiologists utilized in the course of an office-based procedure. I have a right to restrict uses and disclosures of my health information as it pertains to treatment, payment and healthcare operations. If my restrictions are accepted, these restrictions will be binding. I understand that I have a right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect of any actions we have already taken in reliance of this consent.

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am knowingly requesting medical services from Eye Surgeons and Physicians, P.C. By my signature on the acknowledgment signature card provided, I warrant that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under any undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and understand the reasons for and indication for any procedures, I understand that I have the right to refuse such care, except in an emergency.

ACKNOWLEDGEMENT AS SIGNER ON THE ACCOUNT

Upon my signature on the acknowledgement signature card provided, I attest that I have read and understand all the provisions discussed herein. Any questions have been answered to my satisfaction and to the extent where I can place my signature on the signature card provided, conveying in doing so an acknowledgement of my full understanding of my rights and obligations as a patient of Eye Surgeons and Physicians, P.C. Should the patient be a legal minor as defined in the State of NY Statute, I hereby attest as the signer on the acknowledgement signature card that I am the lawful guardian of the minor.

NON-COVERED SERVICES

I understand that Eye Surgeons and Physicians, P.C. contracts with most health care plans. The undersigned accepts full financial responsibility for all items or services which are determined by the health care plans as not covered.

Example of possible non-covered services include: **REFRACTION (92015)** –this test measures the patient for new eyeglasses or verifies that the eye problem is not eyeglass related. **A $30.00 CHARGE MAY BE REQUIRED AT TIME OF YOUR VISIT.**