Avant Garde Vision Center
Dr. Diana Zabarko
506 Hamburg Turnpike Suite 207
Wayne, NJ 07470

Patient Information

Last Name:_____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Last 4 of Social Security: _____

Street Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____Cell Phone: _____Is it okay for us to Text you? Y N

Email address:_____ Is it okay for us to email you? Y N

Employment status: _____Occupation: _____

Emergency Contact: Name, Phone number and relationship to you _____

If you are a new patient, who referred you to our office? _____

Do you wear glasses or contacts? _____

Primary Care Doctor: _____ Phone:_____

List medications and what you are taking them for (If your medications will not fit on this form, please provide us a separate list)

_____

How is your general health? _____

Pharmacy location and phone number: _____

Are **you** under treatment for any of the following conditions? (Please circle if applicable)

Gastrointestinal	Urinary	Endocrine (glands)	Ear/Nose/Throat
Cardiovascular	Nervous System	Blood/Lymph	Muscle/Bones
Allergic/Immunologic	Mental Health	Respiratory	Integumentary (skin)
Headaches	High Blood Pressure	Eye conditions: _____	

Do you have diabetes: Y/N **If yes**, Type _____ Date of diagnosis: __/__/____

Allergies to medications: _____Reaction: _____

Family History (Please circle if applicable)

High Blood Pressure: Relation _____	Macular degeneration: Relation _____
Diabetes: Relation _____	Retinal Detachment: Relation _____
Glaucoma: Relation _____	Cataracts: Relation _____

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Patient Name: _____ Date: ____/____/____

Insurance Information

Vision Insurance _____ ID Number: _____

Subscriber name: _____ Subscriber DOB: _____

Insured's relationship to patient: _____

Medical Insurance _____ ID Number: _____

Subscriber name: _____ Subscriber DOB: _____

Relationship to patient: _____

Financial Agreement

I acknowledge that Dr. Diana Zabarko and staff will verify insurance benefits to the best of their abilities. By signing this form, I understand that verification of insurance benefits is not a guaranteed form of payment. I agree to pay any deductibles, copayments and other fees that may be incurred. I understand that I am responsible for any non-covered or denied services through my insurance company and I will be held responsible for payment to Diana Zabarko OD. If I do not have insurance, I agree to pay in full at the time service.

I agree that in return for the services provided to me by Diana Zabarko OD, I will pay my account at the time service is rendered. If an account is not paid up to date I understand that my account could be sent to an attorney or collection agency. I agree to pay collection expenses and/or reasonable attorney's fees as established by the court.

I understand I will be responsible to pay a $25 charge for any missed or cancelled appointments without 24 hours' notice.

Custom materials will be ordered for you in the form or contacts or glasses and therefore they cannot be returned after the order is placed. Any change in prescriptions or lens redos must be done within 30 days of the original sale or the patient will be financially responsible if they want a lens replacement. If we redo the lenses and incur any shipping fees from the lab, the patient will be responsible for the fees and we will require payment at the time of dispense. We require pick up of glasses and contacts within 30 days of the order. If materials are not picked up, you may be subject to a $35 restocking fee.

HIPAA

Our practice is dedicated to maintaining the privacy of your individual health information. We are required by law to maintain the confidentiality of your health information under the Health Insurance Portability and Accountability Act. We cannot release or discuss personal medical information with anyone unless you have given us written permission to do so.

Patient/Guardian Signature: _____ Date: _____