Rustagi Eye Associates
211 BELLEVUE AVE
Montclair, NJ 07043-9998
(973)-707-5255

PATIENT DEMOGRAPHICS			
Patient Name:		Sex	Social Security Number
Address		Age:	Date of Birth:
City, State, Zip:			
Best Phone Number to Contact You:	Secondary Phone Number:	Best Method to Contact You ?	
Email:		Occupation:	
Employer		Primary Care Physician:	
Notes:		PCP Phone:	

PRIMARY MEDICAL INSURANCE	PRIMARY VISION INSURANCE
Company Name:	Company Name:
Policy ID No.:	Policy ID NO.:
Policy Group:	Policy Group:

SUBSCRIBER / GUARANTOR		
Subscriber Name:	Sex:	Social Security Number:
Address:	Date of Birth:	
City, State, Zip:		
Home Phone:	Work Phone	

FOR OFFICE USE ONLY	
LEP:	
DED STATUS: IP: OOP:	

Patient Signature: _____ Date: _____

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Are you a NEW PATIENT / ESTABLISHED PATIENT (Please Circle One).

How did you find us?_____

What is you reason for your visit today? New Eye Glasses / Contact Lens Fit / Both

Do you have any allergies to medication?:_____

Have you had any eye injuries, eye surgeries, or diseases ? **Yes or No**. Please Explain:_____
Are you currently using any eye drops ? **Yes or No**. If yes, please explain:_____

The Following questions are very important. Please Circle / Describe which apply to you :

RED EYES DRY / ITCHY EYES EXCESS TEARING EYE STRAIN / EYE PAIN

DOUBLE VISION HEADACHES FLASHING LIGHTS FLOATING SPOTS

LOSS OF SIDE VISION LIGHT SENSITIVITY Blurry Vision at : Distance - Near

Do you experience glare while driving at night or when on a computer? (Please Circle One) Yes or No

To better examine your eyes, your pupils must be dilated. A retinal exam with a dilated pupil can discover serious eye or medical conditions such as: Glaucoma, Cataracts, Macular Degeneration, Diabetes, High Blood Pressure, and many more. Please inquire about possible side effects.

Please Circle One: I (do want) / (do not want) a comprehensive dilated exam.

Notice of Privacy available upon request

Patient Signature:_____

In signing this form you are authorizing Upper Montclair Eye Care and wear to bill your insurance for services provided to you and to release any information required to process this claim. You also authorize your insurance benefits to be paid directly to the physician. In case there is a deductible or payment denial, you will be billed accordingly.

GLASSES PRESCRIPTION:

OD:

OS:

CONTACT LENS PRESCRIPTION:

OD:

OS: