Mark R. Fleckner, M.D., P.C.

Vitreo-Retinal Specialists

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Fax: (516) 739 - 6876

61-34 188th Street, Suite 206
Fresh Meadows, NY 1136
Tel: (718) 454 - 7700
Fax: (718) 454 - 7300

PATIENT INFORMATION

Today's Date: _____ Email address: _____

PERSONAL INFORMATION – (Please Print)

Patient Name: _____ Age: _____

Address: _____ City _____ State _____ Zip _____

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

Date of Birth: _____ S.S. #: _____ Sex: Male / Female
Marital Status: Single o Married o Divorced o Widowed o

Language _____ Race _____ Ethnicity _____

Employment Status Employedo Unemployedo Retiredo Disabled o

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Employer: _____ Work Phone: _____

Pharmacy Information _____ City: _____ Phone:_____

Known Allergies _____

Primary Care/ Family Doctor: _____City:_____

General Ophthalmologist/ Optometrist: _____

Neurologist _____ City:_____

Endocrinologist: _____ _____ City:_____

Rheumatologist: _____ City:_____

Complete if under 18 years or a student

Name of Father: _____Social Security # _____Employer: _____

Address: _____Phone: _____

Name of Mother: _____Social Security # _____Employer: _____

Address: _____Phone: _____

Who to notify in an emergency (nearest relative or friend)?

TURN OVER

Name: _____Relationship: _____

Address: _____ Phone: _____

INSURANCE INFORMATION (Please present insurance cards to the front desk)

Primary Insurance: _____ # _____Co-pay Amt: _____

Name of:
Policyholder: _____Social Security # _____Date of Birth: _____

Secondary Insurance: _____ # _____ Co-pay Amt: _____

Name of:
Policyholder: _____Social Security # _____Date of Birth: _____

Referred by:
o Friend/Relative _____ oDoctor: _____

Have you seen our ads? (Please check all that apply):
oYellow Pages o Newspaper oRadio oTelevision oOther: _____

FINANCIAL ASSIGNMENT AND AGREEMENTS

- I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.
- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Mark R. Fleckner, M.D. P.C. for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.
- I understand that I am financially responsible for all charges not covered by insurance.
- Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.
- I authorize Mark R. Fleckner, M.D., P.C. to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.
- I agree to the release of my medical information to my personal physician(s), or optometrist(s).
- **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

  1. _____ 2. _____

I acknowledge that a copy of **Mark R Fleckner, M.D., P.C. Notice of Privacy Practices** has been provided to me for review and that a copy is available at my request. This acknowledgement is for routine use and disclosure of health data including accessing information for treatment purposes, coordinating care with another physician, processing claims and or other payment reasons for health plan operations.

Signature: _____ Date: _____
(Patient or legal guardian)

Witness: _____ Date: _____
(Practice Representative)