PATIENT INFORMATION

VisualEyes, LLC • 1013 Boston Post Rd • Guilford, CT 06437

Name: ____ Gender M / F Today's Date: ____ / ____ / ____

Address: _____________________________________City: _________________ State: _____ Zip: _______

Date of Birth ____ / ____ / ____ Age: __________ Phone: (H) (____) ____ - _______ (C) (____) ____ - _______

Occupation: __________________________________ Email: ___________________________________

Primary Care Physician:__________________________ Town: ________________ Ph# (____) ____ - ______

Reason for Visit (Circle All that apply)

Itching	Y / N	Dryness	Y / N	Spots/Floaters	Y / N	Eye Strain	Y / N
Burning	Y / N	Discharge	Y / N	Flashing lights	Y / N	Pain in eye	Y / N
Redness	Y / N	Swelling	Y / N	Double vision	Y / N	Headache	Y / N
Blurred Vision	Y / N	Tearing	Y / N	Growths	Y / N	Twitching	Y / N

Other:____

Please answer the following questions about your medical status and history:

(Circle those that apply under question) *Please list anything not listed and explain:*

1. Have you ever been treated for any medical conditions? . . . . Y / N ______________________________
   (Diabetes, high blood pressure, high cholesterol, heart disease, thyroid disease, arthritis, autoimmune disorders, other)
2. Are you currently taking any medications, if so list them? . . Y / N ______________________________
3. Have you ever had any eye disease, trauma or surgery? . . . . Y / N ______________________________
   (Glaucoma, cataract, macular degeneration, wandering or "lazy" eye, other)
4. Are you currently using any *eye*-medications? . . . . Y / N ______________________________
5. Are you *allergic* to any medications? . . . . Y / N ______________________________
6. Do any medical diseases run in your family? . . . . Y / N ______________________________
   (Diabetes, high blood pressure, cancer, heart disease, other)
7. Do any eye diseases run in your family? . . . . Y / N ______________________________
   (Glaucoma, cataract, macular degeneration, wandering or "lazy" eye, other)

Do you smoke? Y / N If yes, how much?__________ Do you drink alcohol? Y / N If yes, how much? _________

Review of Systems

Do you currently have any of the following problems? *Please circle all that applies and explain:*

Chronic fever, unexpected weight loss/gain, fatigue, other . . . . Y / N ______________________

Ear/Nose/Throat problems (hearing loss, sinus problems, sore throat, other) . . . . . Y / N ______________________

Heart problems (chest pain, irregular heart beat, other) . . . . Y / N ______________________

Respiratory problems (shortness of breath, wheezing, coughing, other) . . . . Y / N ______________________

Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting, other) . . Y / N ______________________

Urinary problems (pain or discomfort, blood in urine, other) . . . . Y / N ______________________

Skin problems (rashes, excessive dryness, other) . . . . Y / N ______________________

Musculoskeletal problems (muscle aches, joint paint, swollen joints, other) . . . . Y / N ______________________

Neurological problems (numbness, weakness, headaches, paralysis, other) . . . . Y / N ______________________

Psychiatric problems (depression, anxiety, other) . . . . Y / N ______________________

CONTACT LENS PATIENTS

Do you *currently* or have you worn contact lenses? **Y / N** If not, are you *interested* in trying contact lenses? **Y / N**

• **Office Use only** •

Reviewed by:________ ________________________________ Date: ____ / ____ / ____

Insurance Information:

VisualEyes, LLC • 1013 Boston Post Rd • Guilford, CT 06437

Primary Health Insurance: ______________________________ Primary Insured's name: ________________________

Insurance ID: ______________________ Relation to: *self / spouse / dependant* Primary's Birthdate: ___ / ___ / ___

Vision Insurance: ____________________________________ Primary Insured's name: ________________________

Insurance ID: ______________________ Relation to: *self / spouse / dependant* Primary's Birthdate: ___ / ___ / ___

Please Read & Initial: *Vision Insurance (such as VSP, EyeMed, Davis, etc.) covers only "Routine" Services. If there are medical conditions affecting the eyes that are pre-existing or become evident during the examination, such as diabetes, hypertension, dry eyes, glaucoma, etc. – this may require a more extensive examination and/or treatment. In this case, you may need to have their claim submitted to your health plan, as it no longer qualifies as a "Routine" examination.*

Please initial here to indicate that you have read & understood this paragraph:____

Authorization of Insurance Payments:
I authorize the release of any medical or other information necessary to process any insurance claims related to this visit. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to *VisualEyes*.

AND

Responsibility of Payment:
I hereby assume responsibility to pay the costs of all services provided by *VisualEyes* to the patient. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees or collections services needed.
I understand that I am financially responsible for any health insurance deductibles, copayments and non-covered services.

X ____ ________________________

Signature of patient (or parent if minor) Date

HIPAA

Please read and sign the following authorizations:

Acknowledgement of Receipt of Notice of Privacy Practices
In the course of providing service to you, we create, receive and store health information that identifies you.
It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office.
The Notice of Privacy Practices you have been offered describes these uses and disclosures in detail.
Please sign below to acknowledge that you have received the Notice of Privacy Policies from *VisualEyes*.

X ____ ________________________

Signature of patient (or parent if minor) Date

FOR ALL Contact Lens Patients

VisualEyes, LLC • 1013 Boston Post Rd • Guilford, CT 06437

CONTACT LENS PATIENTS
Do you *currently* or have you worn contact lenses? **Y / N**

Type of contacts worn: ❑ Soft ❑ Rigid-gas Perm (RGP)/Hard ❑ Astigmatic/Toric ❑ Bifocal ❑ Monovision ❑ Color
(√ all that apply)

Brand of Contacts worn ______________________________ Cleaning Solution Used ________________________________

How often replaced? ____day____wks____mo____yrs Do you sleep in your contacts? **Y / N** ____________________

Acknowledgement of Contact Lens Fitting / Evaluation / Management Policies

There is a separate annual professional fee (*not included in the eye exam fee*) for all additional tests, measurements and follow-up care involved in the successful fitting, evaluation & management of any type of contact lenses.

Generally, this fee ranges from $60-$175 depending on the complexity and the amount of professional time needed to complete the process. This fee is not covered under most insurance plans, and is therefore, your responsibility to pay at the time of services.

Our goal is to provide you with those contact lenses which are best suited to your particular needs and will result in the best comfort, vision and eye health.

X ____ ____________________________
Signature of patient (or parent if minor) Date