PATIENT INFORMATION

VisualEyes, LLC • 705 Boston Post Rd, Suite A10 • 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

Please tell us who or how you were referred to our office _____

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/followed 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 or ANYTHING else (food/seasonal)? Y / N_____
6. Do ANY medical diseases run in your family? IF SO, WHO? Y / N _____
   (Diabetes, high blood pressure, cancer, thyroid dysfunction, autoimmune disease. other)
7. Do any eye diseases run in your family? IF SO, WHO? . . . . . Y / N _____
   (Glaucoma, cataract, macular degeneration, wandering or "lazy" eye, retinal detachment, other)

Do you or have you ever smoked? If yes, how much? _____ Do you drink alcohol? Y / N 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 ever worn contact lenses? **Y / N** If not, are you *interested* in trying contact lenses? **Y / N**

Insurance Information:

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Primary Health Insurance: _____ Primary Insured's name: _____

Insurance ID: _____ Relation to: *self / spouse / dependent* Primary's Birthdate: ____ / ____ / ____

Secondary Health Insurance: _____ Primary Insured's name: _____

Insurance ID: _____ Relation to: *self / spouse / dependent* Primary's Birthdate: ____ / ____ / ____

Vision Insurance: _____ Primary Insured's name: _____

Insurance ID: _____ Relation to: *self / spouse / dependent* 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*.

X _____ _____

Signature of patient (or parent if minor) Date

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

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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** _____

Do you use any eye drops with contacts? **Y/N** _____ How many hours a day do you wear lenses? _____

Frequency of wear: Daily_____ Occasionally _____Sports Only_____

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 ($75++) depending on the "complexity of the fit" 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