Patient Information

Today's Date: ________________

Mr./Dr./Mrs./Ms./Miss ____ Preferred Name __________________ Sex: M F
Last First MI (If different)

Address____ City___________________________ State__________ Zip___________

Home Phone________________________ Business Phone_______________________ Cell Phone______________________________

Birth Date______________________ Soc. Sec. #_________-_______-____________ e-mail____________________________________

Employer's Name____ Phone _________________________________

Employer's Address____

Account Responsible – If Patient is a Minor or Dependent

Name of person responsible for account ____ Relationship to patient _______________
Last First MI

Address____ City___________________________ State__________ Zip___________

Home Phone________________________ Business Phone_______________________ Cell Phone______________________________

Employer's Name____ Phone _________________________________

Employer's Address____

IF THE PATIENT IS A MINOR or DEPENDENT: I hereby authorize the doctors and/or staff of New England Eyecare to perform diagnostic and therapeutic measures on ____ Date __________________________

Signature of parent or guardian______________________________________ Source of Authority_____________________________

Insurance / Managed Care Information

To enable correct billing, you must provide **any** and **all** health and/or vision coverage, whether or not you believe we participate or you have benefits that apply.

Insurance Company_________________________________ ID#___________________________ Group#_______________________

Name of Insured____ Relationship to Patient_____________________________________

Social Security #____ Birthdate____

Employer's Name____ Phone _________________________________

Employer's Address____

Do you have any additional health or vision insurance? Yes No If yes, please fill out portion below

Insurance Company_________________________________ ID#___________________________ Group#_______________________

Name of Insured____ Relationship to Patient_____________________________________

Social Security #____ Birthdate____

Employer's Name____ Phone _________________________________

Employer's Address____

Financial Arrangements, Insurance, and Privacy Practices

rev. 4/8/13

Our goal is to provide you with the best possible eye care and eyewear products at the lowest cost. Processing insurance claims and collecting unpaid bills requires tremendous staff time and adds considerably to the rising costs of health care. In order to best serve you and all our patients, we need you to understand our payment policies and your vision and/or medical coverage, policies and responsibilities.

- Insurance information is required prior to your visit. If you do not provide us with complete and accurate insurance information prior to your visit, there will be additional fees to reprocess your claims.
- In the case of no insurance, commercial insurances, and non-assignment plans, payment for professional services is required at the time of visit.
- All co-payments, co-insurance, and deductibles applicable to your plan must be paid at the time of visit.
- Not all services are covered benefits in all contracts and you are responsible for understanding your coverage. For example, some plans only cover medical eye care while other plans only cover routine eye care.
- We will submit claims for you to our participating plans. You are responsible for submitting claims to non-participating and non-assignment plans.
- If your plan requires a referral from your primary care physician, it is your responsibility to know if this referral is required, and to obtain this referral prior to the appointment. If this referral is not available when services are provided, or we provide urgent services, or services in good faith contingent upon an expected referral, and this referral is not provided, denied, or not accepted, then you are personally responsible for all charges incurred during your visit.
- Authorization or approval by your insurance company is not a guarantee of payment and information including benefits and co-pays provided to us by insurance companies is often inaccurate. If your plan denies or adjusts your claim for any reason, or you are deemed ineligible at the time of service for any reason, you are responsible for payment of all usual and customary charges to the account not covered by insurance.
- All eyeglass orders, contact lens orders, and replacement orders require a minimum 50% deposit with full payment at delivery. Some discounts, such as vision plan discounts, are available only with payment in full at time of order. Payment may be made by cash, check, MasterCard, Visa, Discover, or American Express. Deposits or payments for services or prescription materials are non-refundable due to their custom nature, once the order is started. However, we do offer a 30-day satisfaction guarantee and will offer an office credit or exchange any product for another if unsatisfactory.
- All fee courtesies require payment in full at visit.
- A $25 fee will be charged for checks returned for non-sufficient funds. Intentional writing of a bad check is a criminal offense in Connecticut. If the returned check and fee are not remedied within 30 days, criminal charges may be filed.

Your signature below constitutes understanding and acceptance of the forgoing and subsequent information and policies.

- I understand it is ultimately my responsibility to understand my insurance coverages, deductibles and co-pays.
- I am financially responsible to New England Eyecare for charges not paid by insurance including deductibles and co-pays.
- I agree to pay an immediate billing charge of $10.00 on any co-pay not paid at the time of visit plus additional billing charges of $10.00 for each month the co-pay remains unpaid.
- I agree to pay a monthly billing charge of $10.00 or 1 ½% per month – APR 18% (whichever is greater), on all amounts remaining unpaid sixty (60) days after the date services or products are rendered.
- If it becomes necessary for New England Eyecare to engage a collection service or bring a lawsuit in order to obtain payment for the amount billed, I agree to pay all costs of collecting my outstanding balance including collection costs, attorney fees and court costs.
- I hereby authorize the responsible insurance carriers to make payable directly to New England Eyecare any medical, vision, or material benefits payable to me as a result of the services performed or materials supplied.
- I further authorize New England Eyecare to release any information needed for the purpose of health care operations, to determine benefits payable and support all claims for related services or materials.
- 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 given describes these uses and disclosures in detail. I acknowledge that I have received the *Notice of Privacy Practices* from New England Eyecare.

Sig. ____ Date ______________________________

Patient (or parent or guardian if minor)

Vision/Medical History

Form Rev. 3/18/13 | Today's Date / /

Name______________________________ Date of Birth ____________ Age _______
Last First MI

Your occupation ______________________ or if a student - current school grade ________

On average, how many hours/day do you spend looking at electronic screens - computers, PDAs, Kindles, iPads, cell phones, etc? _____

On average, how many hours/day do you spend looking at hard copy print - books, newspapers, reports, etc? _____

Visual tasks, Hobbies, Sports (Check and add all that apply)

- ❑ Baseball
- ❑ Basketball
- ❑ Billiards
- ❑ Boating
- ❑ Computers
- ❑ Crafts
- ❑ Fishing
- ❑ Gardening
- ❑ Golf
- ❑ Hunting
- ❑ Piano/Organ
- ❑ Racquetball
- ❑ Reading
- ❑ Shooting
- ❑ Skiing-Snow/Water
- ❑ Swimming
- ❑ Tennis
- ❑ Woodworking
- ❑ ____________
- ❑ ____________

Do you wear glasses? ❑ Yes ❑ No Date of last eye exam ________ Previous eye doctor ____________

Do you wear contact lenses? ❑ Yes ❑ No If yes, what type/brand? ____________

If no, are you interested in wearing contact lenses for vision correction and/or eye color change? ❑ Yes ❑ No ❑ Maybe

Are you interested in information on Laser Vision Correction? ❑ Yes ❑ No ❑ Maybe

How did you hear about us? Who may we thank for recommending us? (Please check one.)

___Relative ___Friend ___Nurse ___Doctor Who may we thank?____________

___Yellow pages ___Coupon ___Insurance company listing ___Newspaper Ad – Which paper?____________

REVIEW OF SYSTEMS

DO YOU TAKE MEDICATION FOR, OR HAVE YOU HAD ANY PROBLEMS OR TREATMENT OF ANY KIND FOR ANY OF THE FOLLOWING CONDITIONS WITHIN THE PAST TWO YEARS:

SYSTEM	YES	NO
CONSTITUTIONAL		
Fever, Weight changes, Fatigue	❑	❑
CARDIOVASCULAR		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
High Cholesterol	❑	❑
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Runny Nose, Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Throat/Mouth	❑	❑
RESPIRATORY		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Genitals/Urinary/Bladder	❑	❑

	YES	NO
MUSCULOSKELETAL		
Osteo or Rheumatoid Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
INTEGUMENTARY (SKIN)		
Rosacea	❑	❑
Skin cancers	❑	❑
NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
PSYCHIATRIC		
Depression/Anxiety	❑	❑
Bipolar disorders	❑	❑
ENDOCRINE		
Diabetes	❑	❑
Thyroid/Other Glands	❑	❑
HEMATOLOGIC / LYMPHATIC		
Anemia	❑	❑
Bleeding Problems	❑	❑
ALLERGIC / IMMUNOLOGIC		
Autoimmune disorders	❑	❑

If you answered YES to any of the above and would like to expand or clarify or have a condition not listed, please explain:

____

____

List all major surgeries and/or hospitalizations you have had: ____________________

____

***   *PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE*   ***

Primary care physician ______________________________ Date of last physical examination ____________________

Address ____________________________________ City ____________________ CT Zip ____________

Phone ____________________________________ Fax ____________________________________

MEDICATIONS

List **any and all** medications you take - of any kind, for any reason (including oral contraceptives, aspirin, recreational drugs, medicated skin creams, inhalers, over the counter medications, and home remedies - or attach list)

❑ None ____

____

____

Are you allergic to any medications? ❑ Yes ❑ No If yes, explain: ____________________________________

EYE CONDITIONS

DO **YOU** CURRENTLY, OR HAVE **YOU** HAD ANY PROBLEMS OR TREATMENT OF ANY KIND FOR THE FOLLOWING EYE CONDITIONS :

DISEASE/CONDITION	YES	NO		DISEASE/CONDITION	YES	NO		DISEASE/CONDITION	YES	NO
Glaucoma	❑	❑		Amblyopia / Lazy Eye	❑	❑		Drooping Eyelid	❑	❑
Cataracts	❑	❑		Dry Eye	❑	❑		Prominent / Bulging Eyes	❑	❑
Macular Degeneration	❑	❑		Flashes / Floaters in Vision	❑	❑		Mucous / Pus Discharge	❑	❑
Eye Injury	❑	❑		Tired Eyes	❑	❑		Eye Redness	❑	❑
Retinal Detachment	❑	❑		Loss of Side Vision	❑	❑		Eye Itching	❑	❑
Other Retinal Disease	❑	❑		Double Vision	❑	❑		Excess Tearing / Watering	❑	❑
Loss of Vision/Blindness	❑	❑		Eye Surgery	❑	❑		Chronic Infection of Eye or Lid	❑	❑
Eye Turn / Strabismus	❑	❑		Distorted Vision / Halos	❑	❑		Styes or Chalazion	❑	❑

If you answered YES to any of the above and would like to expand or clarify or have an eye condition not listed, please explain:

____

____

FAMILY HISTORY

DOES ANY **BLOOD RELATIVE** HAVE A DIAGNOSIS OF OR RECEIVE TREATMENT FOR ANY OF THE FOLLOWING CONDITIONS?

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU		DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Glaucoma	❑	❑			Diabetes	❑	❑	
Cataract	❑	❑			Cancer	❑	❑	
Macular Degeneration	❑	❑			Heart Disease	❑	❑	
Retinal Detachment	❑	❑			High Blood Pressure	❑	❑	
Other Retinal Disease	❑	❑			High Cholesterol	❑	❑	
Amblyopia / Lazy Eye	❑	❑			Thyroid Disease	❑	❑	
Blindness	❑	❑			Rheumatoid Arthritis	❑	❑	
Strabismus / Eye Turn	❑	❑			Lupus	❑	❑	
Other Eye Disease	❑	❑			Other	❑	❑	

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No If yes, please describe:

____

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long: ____________________________

Do you use recreational drugs? ❑ Yes ❑ No If yes, type/amount/how long: ____________________________

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long: ____________________________

Have you ever been exposed to or infected with tuberculosis, hepatitis, HIV, gonorrhea, syphilis, or any other potentially contagious condition?

❑ Yes ❑ No If yes, please specify ____

Are you pregnant or nursing? ❑ Yes ❑ No or N/A