## Welcome to ANDROS GAGLIANI EYE CENTER

Address Who is responsible for this account? Relationship to Insured: Self ② Spouse ③ Child ③ DOB Vision Insurance: ID# Beat insurance:		If no insurance, please proceed to the next section.
Relationship to Insured: Self O Spouse O Child O DOB DOB Sex F O M O Other O Vision Insurance: ID# DOB Age SSN Health Insurance: ID# DOB Age SSN Health Insurance: ID# GRP# Subscriber Name: DOB Best time & way to reach you Is patient covered by additional insurance? Yes O No O List additional insurance: ID# GRP# SSIGNMENT AND RELEASE Is the undersigned, certify that I for my dependent) have insurance coverage and assign directly to Dr. P. Andros-Andrzejewska and Andros Gagliani Eye Center all insurance benefits for services rendered. The assignment will remain in effect until revoked by me in writing. Andros Gagliani Eye Center all insurance benefits for services rendered. The assignment will runderstand that I am financially responsible for all charges whether or no pald or covered by insurance, including the write-off amounts. I hereby submissions.  Cell Phone Occupation Employer Besponsible Party Signature Date  Emergency Contact Name Relationship Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!  Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!		
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Cell Phone Subscriber Name: DOB Please check to opt out of text ○ or email ○ Is patient covered by additional insurance? Yes ○ No ○ List additional insurance:  ASSIGNMENT AND RELEASE Is the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. P. Andros-Andrzejewska and Andros Gagliani Eye Employer Address Center all insurance benefits for services rendered. The assignment will remain in effect until revoked by mix mixing. Andros Gagliani Eye Center all insurance benefits for services rendered. The assignment will remain in effect until revoked by mixing in effects of insurance, leading the write-off amounts. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.  Cell Phone Occupation Employer Responsible Party Signature Date  Emergency Contact Name Relationship Cell Phone Work Phone Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!  Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!  Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!  Rease review our office policies below:  Ill co-pays (vision and medical) are due at the time of service. Patient is responsible for immediate payment of all harges not covered by insurance. No refunds, exchanges, or remakes after 30 days from original purchase date. We rovide you with custom products especially designed for you therefore there is a 30% service charge (of the origina)		
Email Please check to opt out of text O or email O	Cell Phone	
Best time & way to reach you  List additional insurance:  ASSIGNMENT AND RELEASE I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. P. Andros-Andrzejewska and Andros Gagliani Eye Center all insurance benefits for services rendered. The assignment will remain in effect until revoked by me in writing. Andros Gagliani Eye Center all insurance benefits for services rendered. The assignment will remain in effect until revoked by me in writing. Andros Gagliani Eye Center reserves the right to refuse assignment of benefits for some insurance plans I understand that I am financially responsible for all charges whether or no paid or covered by insurance, including the write-off amounts. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.  Cell Phone  Occupation  Employer  Work Phone  Responsible Party Signature  Date  The work of the did you hear about our office  Work Phone  Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!  Ilease review our office policies below:  Ill co-pays (vision and medical) are due at the time of service. Patient is responsible for immediate payment of all harges not covered by insurance. No refunds, exchanges, or remakes after 30 days from original purchase date. We rovide you with custom products especially designed for you therefore there is a 30% service charge (of the origina)		
Occupation	•	Is patient covered by additional insurance? Yes O No O
Occupation	Best time & way to reach you	List additional insurance:
Employer Address		
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We welcome you to our office. We strive to achieve excellent patient satisfaction and to make your experience here

exceptional.

Patient Name								
Reason for you	r visit to	day						
Do you wear glasses? OAll the time ONever OSometimes ODriving only OComputer/ reading only								
Are you happy w How often do yo	vith those ou replace	contacts? your conta	O Yes O No	ly O Weekly O Biweekly O Mc	onthly <b>O</b> Other			
Check off any of	the follow	ving that yo	ou currently experi	ence.				
O Dry Eyes	O Water	ing eyes	O Variable or blo	urry vision O Itchy eye				
O Headache	O Light s	sensitivity	O Floaters or sp	ots/flashes • O Poor night vision	on			
O Red eyes	O Doubl	e vision	O Discharge from	m eyes O Eye strain				
Are you interested Yes ONo	ed in Orth	okeratolog	gy (wearing contact	lenses at night and no need fo	r prescription (	during the day)?		
Are you intereste	ed in Myo	pia Manag	ement (slowing the	e progression of nearsightednes	ss)? O Yes O	No		
3. Health History								
Physician's name	e		Da	te of last visit				
Please check all t	that apply							
		Yourself	Family members (Blood relatives)	11	Yourself	Family members (Blood relatives)		
AIDS/HIV Arthritis		<b>O</b>	0	Hepatitis (Type) High blood pressure	0	<b>O</b>		
Artificial heart	مبادي	0	0	Kidney disease	0	0		
Artificial joints	vaive	0	Ö	Lazy eye	o	o		
Asthma		Ö	Ö	Lupus	o	Ö		
Bleeding		Ö	o	Migraines	O O	Ö		
Blindness		Ō	O	Pacemaker	O	O		
Cancer		Ö	O	Poor color vision	O	O		
Cataracts		O	Q	Retinal Disease	Q	O		
Chemical deper	ndency	Ö	O	Rheumatic fever	Q	O		
Diabetes	,	•	O	Shingles	O	O		
Drug sensitivity	,	O	O	Skin conditions	O	O		
Emphysema		O	O	Stroke	O	O		
Epilepsy		$\mathbf{O}$	O	Thyroid conditions	O	O		
Eye surgery		O	O	, Tuberculosis	O	O		
Glaucoma		$\mathbf{C}$	O	Turned eye	O	O		
Hay fever		O	O	Are you pregnant? O Yes O N	lo Number o	f children		
Heart condition	)	•	O	Tobacco use		se		
List any eye heal	th conditi	ons you ha	ve					
List any eye surg	eries you'	ve had						
List any other me	edical con	ditions						
List any medicati	ions you a	re currentl	ly taking					
List your allergie	s							