Welcome to

ANDROS GAGLIANI EYE CENTER.

CONFIDENTIAL INFORMATION FOR THE DOCTOR OF OPTOMETRY

1 *PATIENT INFORMATION*

Date _____

Patient _____
(Please Print)

Address _____

_____
City State Zip

Sex: ❑M ❑F Age____ **Birthdate** _____

Patient SS# _____

❑ Single ❑ Married ❑ Other

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____ Ext. _____

Occupation _____

Employer _____

Employer Address _____

Best time & place to reach you _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Spouse's Work Phone _____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household)

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

★ **Whom may we thank for referring you?** _____

_____

2 *INSURANCE*

Who is responsible for this account? _____
If no insurance, proceed to next section

Relationship to Patient _____ DOB___/___/____

Vision Insurance _____

ID # _____

Group # _____

Claim Address _____

Telephone # _____

Health Insurance _____

ID # _____

Group # _____

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Claim Address _____

Telephone # _____

Is patient covered by additional Insurance? ❑ Yes ❑ No

List additional insurance:

_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have Insurance coverage with _____ and assign directly to Dr. P. Andros-Andrzejewska and Andros Gagliani Eye Center all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid 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.

_____
Responsible Party Signature

_____
Relationship to Patient Date

If you'd like to receive email information from us please indicate your email address: _____

Please review our office policies below:

All co-pays (vision and medical) are due at the time of service. Patient is responsible for immediate payment of all charges not covered by insurance. No refunds, exchanges or remakes after 30 days from original purchase date. There is a 30% service charge (of the original charges) for all cancellations and returns. There is no exchange or return on special orders. We are not responsible for items left for more than 90 days.

We welcome you to our office. We strive to achieve excellent patient satisfaction and to make your experience here exceptional.

I understand all office policies: _____
Patient/Parent/Guardian Signature Date

Patient Name:_____

3 *EYE HEALTH HISTORY*

Reason for your visit today _____

_____

Date of last eye exam? _____

Name of Doctor _____

Do you wear glasses? ❑Yes ❑No

❑All the time ❑Occasionally

❑Reading ❑Driving ❑TV

Do you wear contacts? ❑Yes ❑No

Type_____ Hours/Day____

Name of cleaner you use _____

Describe any problems you have with your contacts_____

_____

Please check all that apply:

Bloodshot Eyes	❑	Fainting Spells, Blackouts	❑
Distance Blur	❑	Floaters or Spots	❑
Reading Blur	❑	Glaucoma	❑
Burning Eyes	❑	Headaches	❑
Cataracts	❑	Itching Eyes	❑
Poor Color Vision	❑	Light Sensitive	❑
Crossed/Lazy Eye	❑	Loss of Vision	❑
Discharge from Eyes	❑	Migraine Headaches	❑
Dizzy Spells	❑	Poor Night Vision	❑
Double Vision	❑	Red Eyes	❑
Dry Eyes	❑	Seeing Halos	❑
Eye Infection	❑	Seeing Flashes	❑
Eye Injury	❑	Temporary Loss of Vision	❑
Eye Strain	❑	Twitching Eyelid	❑
		Poor Vision	❑
		Watering Eyes	❑

List any eye disease:_____

_____

4 *HEALTH HISTORY*

Physician's Name_____Date of Last Visit_____

Please check all that apply. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	❑	❑	Hepatitis (Type ____)	❑	❑
Arthritis	❑	❑	High Blood Pressure	❑	❑
Artificial Heart Valve	❑	❑	Kidney Disease	❑	❑
Artificial Joints	❑	❑	Lazy Eye	❑	❑
Asthma	❑	❑	Lupus	❑	❑
Bleeding	❑	❑	Migraine Headaches	❑	❑
Blindness	❑	❑	Pacemaker	❑	❑
Cancer	❑	❑	Poor Color Vision	❑	❑
Cataracts	❑	❑	Retinal Disease	❑	❑
Chemical Dependancy	❑	❑	Rheumatic Fever	❑	❑
Diabetes	❑	❑	Shingles	❑	❑
Drug Sensitivity	❑	❑	Skin Conditions	❑	❑
Emphysema	❑	❑	Stroke	❑	❑
Epilepsy	❑	❑	Thyroid Conditions	❑	❑
Eye Surgery	❑	❑	Tuberculosis	❑	❑
Glaucoma	❑	❑	Turned Eye	❑	❑
Hay Fever	❑	❑	Are you pregnant?_____	Number of Children_____	
Heart Condition	❑	❑	Tobacco use _____	Alcohol use_____	

List any other medical conditions _____

MEDICATIONS

List medications you are currently taking, including eye drops: and over the counter medications or nutritional supplements:

_____

_____

_____

_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____