*Welcome to*

# ANDROS GAGLIANI EYE CENTER

## *1*. *Patient Information* Date_____

Patient Name_____
Address _____
_____

Sex F ❍ M ❍ Other ❍ _____

DOB _____ Age _____
SSN _____
Single ❍ Married ❍ Other ❍

Cell Phone_____
Email _____
Please check to opt out of text ❍ or email ❍
Best time & way to reach you
_____

Occupation _____
Employer _____
Employer Address _____
Work Phone _____

Spouse Name _____
DOB _____
SSN _____
Cell Phone _____
Occupation_____
Employer _____
Work Phone_____

Emergency Contact Name _____
Relationship _____
Cell Phone _____
Work Phone _____

## *2*. *Insurance*

If no insurance, please proceed to the next section.
Who is responsible for this account? _____
Relationship to Insured: Self ❍ Spouse ❍ Child ❍
DOB _____
**Vision** Insurance: _____
ID# _____

**Health** Insurance: _____
ID# _____
GRP# _____
Subscriber Name: _____
DOB _____
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 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 reserves the right to refuse assignment of benefits for some insurance plans. **I understand that I am financially responsible for all charges whether or not 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.

_____
Responsible Party Signature Date

How did you hear about our office _____

Remember to Like us on Facebook and Follow us on Instagram (ag.eyecenter)!

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. We provide you with custom products especially designed for you therefore there is a 30% service charge (of the original charges) for all cancellations and returns. There is no exchange or returns on special orders, colored contact lenses, or outside prescriptions. There are no remakes or prescription adjustments for outside prescriptions. 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* _____

*Reason for your visit today* _____

Do you wear glasses? ❍All the time ❍Never ❍Sometimes ❍Driving only ❍Computer/ reading only

If you wear contact lenses, what brand are they? _____
Are you happy with those contacts? ❍ Yes ❍ No
How often do you replace your contact lenses? ❍ Daily ❍ Weekly ❍ Biweekly ❍ Monthly ❍Other_____
What solution do you use? _____

Check off any of the following that you currently experience.

| | | | |
|---|---|---|---|
| ❍ **Dry Eyes** | ❍ Watering eyes | ❍ Variable or blurry vision | ❍ Itchy eye |
| ❍ Headache | ❍ Light sensitivity | ❍ Floaters or spots/flashes | ❍ Poor night vision |
| ❍ Red eyes | ❍ Double vision | ❍ Discharge from eyes | ❍ Eye strain |

Are you interested in Orthokeratology (wearing contact lenses at night and no need for prescription during the day)?
❍ Yes ❍No

Are you interested in Myopia Management (slowing the progression of nearsightedness)? ❍ Yes ❍ No

## 3. *Health History*

Physician's name _____ Date of last visit _____

Please check all that apply.

| | Yourself | Family members (Blood relatives) | | Yourself | Family members (Blood relatives) |
|---|---|---|---|---|---|
| AIDS/HIV | ❍ | ❍ | Hepatitis (Type ___) | ❍ | ❍ |
| Arthritis | ❍ | ❍ | High blood pressure | ❍ | ❍ |
| Artificial heart valve | ❍ | ❍ | Kidney disease | ❍ | ❍ |
| Artificial joints | ❍ | ❍ | Lazy eye | ❍ | ❍ |
| Asthma | ❍ | ❍ | Lupus | ❍ | ❍ |
| Bleeding | ❍ | ❍ | Migraines | ❍ | ❍ |
| Blindness | ❍ | ❍ | Pacemaker | ❍ | ❍ |
| Cancer | ❍ | ❍ | Poor color vision | ❍ | ❍ |
| Cataracts | ❍ | ❍ | Retinal Disease | ❍ | ❍ |
| Chemical dependency | ❍ | ❍ | Rheumatic fever | ❍ | ❍ |
| Diabetes | ❍ | ❍ | Shingles | ❍ | ❍ |
| Drug sensitivity | ❍ | ❍ | Skin conditions | ❍ | ❍ |
| Emphysema | ❍ | ❍ | Stroke | ❍ | ❍ |
| Epilepsy | ❍ | ❍ | Thyroid conditions | ❍ | ❍ |
| Eye surgery | ❍ | ❍ | Tuberculosis | ❍ | ❍ |
| Glaucoma | ❍ | ❍ | Turned eye | ❍ | ❍ |
| Hay fever | ❍ | ❍ | Are you pregnant? ❍ Yes ❍ No | Number of children _____ | |
| Heart condition | ❍ | ❍ | Tobacco use _____ | Alcohol use _____ | |

List any eye health conditions you have _____

List any eye surgeries you've had _____

List any other medical conditions _____

List any medications you are currently taking _____

List your allergies _____