FAMILY EYE CENTER
& Contact Lens Specialists

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date ______________________________

Last Name ______________________________

First Name ______________ Middle Initial ____

SS # ______________________________

Address ______________________ Apt ________

City ______________ State ______ Zip ________

Sex ☐M ☐F Age _____ Birthdate ______________

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for _____ years

Occupation ______________________________

Patient's Employer/School ______________________

Has any family member/friend been here before? ☐Yes ☐ No

If yes, who? Name ______________ Relation __________

PHONE NUMBERS/E-MAIL

Home ______________________________

Cell ______________________________

Work ______________________________

Other ______________________________

Best time & place to reach you ______________

e-mail ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________________________

Home ______________________________

Cell ______________________________

Work ______________________________

Whom may we thank for referring you? ______________

EYE HEALTH HISTORY

I would like to see the doctor today for a/an: ☐Annual eye health evaluation ☐Annual contact lens evaluation ☐Medical Visit

☐Lasik Consultation ☐LATISSE® ☐Other ______________________________

Date of last eye exam ______________ Doctor's Name ______________________

Do you wear glasses? ☐Yes ☐ No If yes, when? ☐All the time ☐Occasionally ☐Reading ☐Driving ☐TV

Do you wear contacts? ☐Yes ☐ No If yes, what brand? ______________________ Hours/day __________

Describe any problems you have with your contacts ______________________________

Do you have any eye conditions or problems? ☐Yes ☐ No If yes, what kind? ______________________

Have you had any eye operations? ☐Yes ☐ No If yes, what kind? ______________________ Date __________

Have you had any eye injuries? ☐Yes ☐ No If yes, what kind? ______________________ Date __________

Do you suffer from: ☐ Migraines ☐ Allergies ☐ Glaucoma ☐ Blurred Vision ☐ Retinal Detachment

☐ Cataracts ☐ Dry eyes ☐ Sensitivity to Light ☐ Poor Vision at Night ☐ Eye Strain/Pain

MEDICAL HISTORY

There are several ocular side effects from many of the commonly prescribed oral medications. Please list your current medications, including oral medications and eye drops. ______________________________

____

Do you have problems with any of these systems?

☐High Blood Pressure ☐Nervous ☐Endocrine ☐Ears/Nose/Throat ☐Urinary ☐Blood/Lymph

☐Gastrointestinal ☐Headaches ☐Eyes ☐Integumentary (skin) ☐Mental ☐Respiratory

Please explain ______________________________

Diabetes? ☐Yes ☐ No If yes, what type? ______________________________

Allergies to medication? ☐Yes ☐ No Which? ______________________ Reactions? ______________

Other health problems ______________________________

Have you had any operations? ☐Yes ☐ No Kind? ______________________ Date __________

FAMILY MEDICAL HISTORY

Name of family doctor ____ Date of last visit ______________

Does anyone in your family have any of these conditions/diseases?

☐High blood pressure Relation ______________ ☐Macular Degeneration Relation ______________

☐Diabetes Relation ______________ ☐Retinal Detachment Relation ______________

☐Glaucoma Relation ______________ ☐Cataracts Relation ______________

FINANCIAL & INSURANCE POLICIES

Family Eye Center, Inc. is a provider for most vision plans; however, authorization must be obtained prior to services/products rendered. Please notify the office of any insurance you are using today.
Insurance Company(ies) ____

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Member/Subscriber Name Member/Subscriber ID or SS# Relationship to Patient

ASSINGNMENT AND RELEASE

Dr. Massimo Gramanzini and Family Eye Center, Inc. may use my heath care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

I certify that I, and/or my dependent(s), have insurance coverage with the above Insurance Compay(ies) and assign directly to Dr. Massimo Gramanzini and Family Eye Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

MEDICARE

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Massimo Gramanzini and Family Eye Center, Inc. for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

FINANCIAL POLICY

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist. Family Eye Center, Inc. cannot bill insurance after services/products have been rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Who is responsible for this account? ______________________________ Relationship to Patient ____________________

I attest that all information provided on this form is accurate.

X

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Signature of Patient, Parent, Guardian Please Print Name of Patient, Parent, Guardian Date

HIPAA

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________________, have reviewed/received a copy of Family Eye Center, Inc.'s Notice of Privacy Practices.

X ____

Signature of Patient/Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

____

Date Initials Reason