

CONSULTING OPHTHALMOLOGISTS, P.C.

INFORMATION TO BE COMPLETED

Information about you and your health is essential for us to provide you with the best possible care. With this in mind, we ask that you complete the enclosed information forms which will assist us in preparing your medical record and expedite the check-in process. Please bring in all completed forms with you the day of your appointment. Please do not mail the forms back to the office.

PATIENT INFORMATION FORM

Please complete information about where you live, work and especially your occupation. Your eye care needs may be related to your job duties.

MEDICAL HISTORY FORM

MEDICATION LIST

Please complete this form making sure you have included name, dose and other information about all medication you take. Please include any vitamins, herbal medications and any over-the-counter medications you are currently taking.

INSURANCE CARDS – We will need to copy your insurance card when you arrive. Please be prepared to pay your co-payment and bring your referral with you if one is required for medical services. If you are unsure of whether a referral is needed, please call your insurance company to get this information. If you will be using your Vision/Eyewear benefit for a non-medical visit, please let us know at check-in as we will need the subscriber's identification number. **Medicare patients** – please be sure you bring *both* your Medicare card and any Medicare HMO card you may have.

REFRACTION – A refraction is a measurement to determine your best possible vision and may result in prescription for eyeglasses. A refraction helps the doctor to distinguish problems caused by eye disease from those which can be corrected by eyeglasses. A refraction is not covered by Medicare or most insurance plans; therefore we will collect a \$25.00 fee from you for this service at the time of your visit. As a courtesy, we will bill your insurance company at your request. Any payment received from your insurance company for the refraction will be refunded to you.

Our office hours are Monday through Friday 8:00 a.m. to 5:00 p.m. If you are unable to keep this appointment or have questions regarding an appointment, please call our office at (860) 678-0202 or in the Glastonbury area at (860) 368-2235. Directions to our offices are also on our website.

PLEASE COMPLETE FORM ON REVERSE SIDE.

**PLEASE BRING ALL COMPLETED FORMS WITH YOU
TO YOUR APPOINTMENT.**

CONSULTING OPHTHALMOLOGISTS, P.C.

Wear now: _____ C/L _____ Glasses
Need: _____ C/L _____ Glasses
Eye Surgery _____
Eye Injury _____
Eye Disease _____
Other _____

499 FARMINGTON AVENUE

FARMINGTON, CT 06032

704 HEBRON AVENUE • SUITE 200

GLASTONBURY, CT 06033

(860) 678-0202

Website: www.consultingeye.com

Farmington / Glastonbury

Dr. _____

Date _____

Time _____

Name _____ D.O.B. _____ Sex _____

Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Phone () _____ Bus. Phone () _____ E-mail _____

Soc. Security # _____ Employer _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employed Since _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy Holder _____ D.O.B. _____

Primary Holder's SS # or ID # _____ Group # _____ Employer _____

Secondary Insurance Co. _____ Policy Holder _____ D.O.B. _____

Policy Holder's SS # or ID # _____ Group # _____ Employer _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____ Home Phone () _____ Work Phone () _____

Address _____ City _____ State _____ Zip _____

REFERRAL INFORMATION

Name of Referring Party _____ Phone () _____

Name of Primary Care Physician _____ Phone () _____

FINANCIALLY RESPONSIBLE PARTY – Must be completed if patient under 18 or a student.

Name _____ Relationship _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Bus. Phone () _____ Soc. Security # _____

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to the doctor of any medical benefits otherwise payable to me. I understand I am financially responsible to him for charges not covered by this assignment. I authorize him to release any information requested to support my claim including any information which constitutes a psychiatric communication and/or relates to treatment of alcohol and drug abuse. If any disclosed information contains AIDS/HIV information, state law prohibits further disclosure without specific written consent.

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default.

SELF-REFERRAL ACKNOWLEDGMENT

I understand that if at any time my insurance plan may not cover my services and I agree to pay all charges.

Signature

Date

| | | | | |
|-----------------|----------------|----------|--------|-----------------|
| Office Use Only | Account Number | Dr. Code | DOCTOR | Office Use Only |
| | | | | |

PATIENT MEDICAL HISTORY RECORD

GENDER: M F

PATIENT NAME (LAST, FIRST) _____

BIRTHDATE (MM/DD/YY) _____

What is the reason for your appointment today? _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?

Yes ___ No ___ If YES, please explain: _____

2. Have you ever had any eye disease or injury (e.g. glaucoma, cataract, lazy eye, or retinal detachment)?

Yes ___ No ___ If YES, please explain: _____

3. Have you ever had surgery?

Yes ___ No ___ If YES, please provide date and procedure: _____

4. Have you ever been hospitalized? If YES, please provide date and reason: _____

5. Do you take any medications for general health (including aspirin, vitamins and herbals)?

Yes ___ No ___ If YES, please list: _____

Do you take any eye medications (including drops, ointments and pills)?

Yes ___ No ___ If YES, please list: _____

6. Do you have any drug or food allergies?

Yes ___ No ___ If YES, please list: _____

Review of Systems

Do you currently have any of the following problems?:

Chronic fever, unexpected weight loss/gain, fatigue

Yes No

___ ___

Ear/nose/throat problems (e.g. hearing loss, sinus, sore throat)

___ ___

Heart problems (e.g. chest pain, irregular heartbeat)

___ ___

Respiratory problems (e.g. shortness of breath, wheezing, cough)

___ ___

Gastrointestinal problems (e.g. heartburn, belly pain, diarrhea, nausea)

___ ___

Urinary problems (e.g. pain, frequent urination, blood in urine)

___ ___

Skin problems (e.g. rashes, dermatitis, excessive dryness and itching)

___ ___

Musculoskeletal problems (e.g. muscle aches, joint pain or swelling)

___ ___

Neurological problems (e.g. numbness, weakness, headaches)

___ ___

Psychiatric problems (e.g. depression, anxiety)

___ ___

If YES, please explain: _____

Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, glaucoma, cataract, macular degeneration)?

Yes ___ No ___ If YES, please explain: _____

Do you smoke? Yes ___ No ___ If YES, how much? _____

Do you drink alcohol? Yes ___ No ___ If YES, how much? _____

Any other medical issues not addressed above? _____

Patient Signature

M.D. Signature

Date (MM/DD/YY)

