WELCOME !!!

Thank you for choosing our office for all your eye care needs. Please take a few minutes to completely fill out this form with the information as you would like for it to appear in our records. If you have any questions we will be glad to help you.

Today's Date________________

Demographics

Last Name______________________________ **First Name**_________________ **MI**_____ **Title**____________

Address________________________________ **City**______________ **State**______ **Zip Code**___________

Home Phone ___________________ **Cell Phone**____________________ **Work Phone**___________________

Gender M F **Birthdate**____________________ **Social Security Number** __________________________

Marital Status____________ **Occupation**_____________________ **Employer**________________________

Employment Status __________________________

Whom may we thank for referring you? Telephone Book Church Bulletin Newspaper Ad Website Friend Insurance

Other____

Financial Information

Party Responsible for Payment____

Relationship to Patient____

☐ **Please check if address is the same as above. Please complete below if different:**

____

____

____

I understand that payment in full for all services rendered are due and payable upon completion of the office visit. Also, at least fifty percent deposit is required before any products will be ordered. Please initial ____________

Vision Insurance

Insured's Name__________________________ **Insured's ID Number**_________________

Relationship to Insured______________________________________

I understand that if my eligibility cannot be verified, if I do not obtain proper referral forms when required, or if my insurance makes a mistake as to my eligibility for services or products, I will be financially responsible for payment of all charges incurred for services and products received from Dr. Mansueto. If we agree to file your insurance for you, it will be done promptly. However, if we do not hear from the insurance company within six weeks, the full balance becomes your responsibility. Please initial____________

Insurance Authorization

I request that payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Dr. Andrew F. Mansueto for any services and/or products furnished by him. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Signature of beneficiary____ **Date**________________

(OVER)

Vision Information

Date of last eye examination________________________ How old are your glasses?________________

Are you having difficulty seeing with your glasses? Y N Are you interested in wearing Contact Lenses? Y N

Are you interested in LASIK corrective surgery? Y N

Do you experience headaches that you feel are related to your vision?____________

Since your last eye examination have you noticed:
Black Spots? Y N
Light Flashes? Y N
Double Vision? Y N

Please circle below all conditions that apply to your eyes:

Burn Itch Dry Light Sensitive Water Discharge

Glaucoma Cataract Iritis Blacking out of Vision Dry Eyes Macular Degeneration

Eye Surgeries Eye infections that affected your vision Eye injuries that affected your vision Lazy eye

Additional Information____

Medical Information

Name of Family Doctor________________________________ Last Visit______________

Current Medications: ____

____

List any allergies to medications____

Do you have Diabetes? Y N Date of Diagnosis__________________________

Do you have a history of Stroke? ____________ Cancer?__________

Please circle the systems below in which you have problems and briefly explain:

Gastrointestinal Ears/Nose/Throat Cardiovascular Respiratory

High Blood Pressure Nervous Urinary Muscles/Bone Eyes

Integumentary (skin) Endocrine (glands) Blood/Lymph Headaches

Mental Allergic/Immunologic

Do you smoke cigarettes? ____________________

Please circle the conditions below that run in your family:

Diabetes High Blood Pressure Glaucoma Cataract Macular Degeneration/Retinal Disease

HIPPA

May we leave a message on your answering machine or with someone at your home regarding your eye appointment or picking up products from the office? Y N May we call you at work or leave a message at work? Y N

Doctor Use Only

Reviewed by ________ Date ________ ☐ No Changes Reviewed by ______ Date ________ ☐ No Changes

Reviewed by________Date________ ☐ No Changes Reviewed by______Date_______ ☐ No Changes