Dr. Andrew F. Mansueto - Optometrist

942 Richard Road Dyer, IN 46311 (219) 864-1430

Welcome, thank you for choosing our office! Please fill out this form with your most updated information as you would like for it to appear in our records

Today's Date: ____________________

Last Name: ____________________ First Name: ____________________ MI: ______ Title: ______
Address: ____________________ City: ____________________ State: ______ Zip: ______

Home Phone: ____________________ Cell Phone: ____________________
E-mail Address: ____________________

Birthdate: ____________________ Gender: ____________________ Marital Status: ____________________
Occupation: ____________________ Employment Status: ____________________ Employer: ____________________

HIPAA:

- May we leave a message on your answering machine/voicemail or with someone in your home regarding your eye appointment or picking up products from our office? Yes or No
- May we release your records to your insurance company if requested? Yes or No
- I acknowledge that I have received a copy of Dr. Andrew F. Mansueto's NOTICE OF PRIVACY PRACTICE: Initial ______

INSURANCE INFORMATION

Name of Insurance ____________________ Name of Insured ____________________

Insured ID or Last 4 Numbers of Social Security ____________________

Relationship to Insured ____________________

INSURANCE AUTHORIZATION

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

Signature of Beneficiary: ____________________

I understand that I am financially responsible for all charges not paid for by my insurance company. Initial ______

Party Responsible for Payment ____________________ Relationship to Patient ____________________

I understand that once my insurance claim is filed, it is final. Charges cannot be reversed and a different insurance filed. Initial ______

PRODUCT REFUND/EXCHANGES

I understand that the eyeglass frame I choose is final. Changes to eyeglass frames require new eyeglass lenses to be fabricated. I agree to a $75.00 non-refundable restocking fee if I wish to exchange my eyeglass frame. Initial ______

I understand that if I am unable to adapt to wearing a progressive lens in my eyeglasses, my eyeglass lenses will be made into a different style at no charge to me but there will be NO refund on any payment made on the original progressive lens. Initial ______

Dr. Andrew F. Mansueto
OPTOMETRIST

VISION INFORMATION

Date of Last Eye Examination:________________________ Age of Current Glasses: _____________________________

Are you having difficulty seeing with your glasses? Yes or No

Are you interested in wearing contact lenses? Yes or No

Are you interested in LASIK corrective surgery? Yes or No

Do you experience headaches that you feel are related to your vision? Yes or No

Since your last eye exam have you noticed black spots? Yes or No Light flashes? Yes or No Double Vision? Yes or No?

Please circle all conditions that apply to your eyes:

Burn	Itch	Dry	Water	Discharge	Light Sensitive
Glaucoma	Cataract	Iritis	Dry eyes	Macular Degeneration	Blacking out or vision
Eye Surgeries	Lazy Eye	Eye infections that affect your vision			Eye injuries that affected your vision

MEDICAL INFORMATION

Name of Family Doctor _____________________________________ Date of Last Visit ___________________________

Current Medications: ____

____

List Any Allergies to Medications:____

Do you have diabetes? Yes or No Date of Diagnosis _______________________________________

Do you have a history of strokes? Yes or No

Do you have a history of cancer? Yes or No Type:____

Please circle all medical conditions that apply to you:

Heart	High Blood Pressure	Respiratory	Thyroid	Headache	Ear/Nose/Throat
Skin	Allergies	Blood	Cancer	Mental Health	
Stomach	Urinary	Muscle/Bone			

Please circle all conditions that run in your family:

Diabetes Glacoma Retinal Disease Corneal Disease

Do you have a cough, fever, or loss of taste or smell NOT from allergies? Yes or No

If you have been around someone with COVID-19 in the past five (5) days, have you screened yourself (by RAPID or PCR testing) prior to arriving at our office? Yes or No

I understand that based upon CDC recommendations, I may be required to wear a mask while at the office of Dr. Andrew F. Mansueto. I agree to comply, when at the the office of Dr. Andrew F. Mansueto, with any mask requirement.

SIGNATURE:____