

Dr. Paul
Cinalli

Dr. James
Liston

Dr. Kenneth
Lord

Dr. David
Tetrault

Dr. Kenneth
Welsh

Dr. Dale
Sarratt

Dr. Paula
Peterson

Dr. Victor
Arias



WELCOME TO OUR OFFICE!

Date _____

Patient's Name: (PLEASE PRINT) _____
Last First

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Occupation: _____ Place of Employment: _____

Date of Birth: ____/____/____ Age: _____ Male/Female _____ Married _____ Single _____ Other _____
(Circle One)

Which vision insurance group do you belong to? _____

Your reason(s) for visiting our office today: (Please check appropriate items)

- | | | |
|--|--|--|
| <input type="checkbox"/> General annual exam (no specific problem) | <input type="checkbox"/> Blurred near vision | <input type="checkbox"/> Eyes water |
| <input type="checkbox"/> Lost or broken eyeglasses | <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Eyes itch |
| <input type="checkbox"/> Want new eyeglasses | <input type="checkbox"/> See "spots" or flashes | <input type="checkbox"/> Eyes feel dry |
| <input type="checkbox"/> Want contact lenses - Currently wear C.L. | <input type="checkbox"/> Double vision | <input type="checkbox"/> Pain in eyes |
| <input type="checkbox"/> Want contact lenses - Never worn C.L. | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Problem with present contact lenses | <input type="checkbox"/> Eyes feel tired | |
| ____ soft ____ rigid gas perm | <input type="checkbox"/> Other (please list) _____ | |
| ____ disposable ____ tinted | | |
| ____ toric ____ bifocal contact lenses | | |

Eye Health: Have you had any eye disease that required medication, treatment or surgery?

No _____ Yes _____ If yes, describe: _____

Date of Last Eye Exam: _____ When was your last dilated exam? _____

Do you wear glasses? No _____ Yes _____ If yes, since when? _____

Do you have your last prescription glasses with you? No _____ Yes _____

Have you noticed any changes in your vision? No _____ Yes _____ If yes, describe _____

About Your General Health- past or present:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Good general health | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Retinal disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> HIV | <input type="checkbox"/> Eye injuries |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Pain in eyes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> "Lazy Eyes" | <input type="checkbox"/> Turned eye |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | _____ |
| | | _____ |

Has anyone in your family (blood relatives) had any of the above conditions? No _____ Yes _____

If so, what relative? What condition(s)? Please list here (do not check in list above). _____

Name _____ Date _____
Last First

(Continued from page 1)

Are you allergic to any medications? No ___ Yes ___ If yes, please list _____

Please list any medications you are currently taking. _____

Use of Tobacco Products? No ___ Yes ___ Occasionally ___ Use of Alcohol Products? No ___ Yes ___ Occasionally ___

Help us to Better Serve your Lifestyle Vision Needs.

In which activities do you participate?

Computers (How many hours per day?) _____ Close Work _____

Sports _____ Hobbies _____

HIPPA PRIVACY PRACTICES

Our Notice of Privacy Practices (NPP) provides information about the privacy rights of our clients, and how we may use or disclose protected health information (PHI) about our clients as mandated by HIPPA laws.

Federal regulations require that we give our clients, or their authorized representatives, the opportunity to review our NPP before signing this acknowledgement. A one-page summary of our NPP is available upon request and is on display in our offices. You may also view our notice by visiting our Internet Website www.alvernonoptical.com and choosing HIPPA Privacy.

If you have any questions about your rights or our privacy practices, please feel free to ask to speak to our HIPPA compliance officer.

FINANCIAL POLICY

If you have insurance that we *do not* contract with, you will be expected to make full payment at the time of service. If you have insurance that we *do* contract with, you will be required to pay your co-payment and all non-covered services at the time of your visit. Insurance information must be provided *prior* to services being rendered; otherwise the services will be considered private pay and be due at the time of service. If coverage is denied for any reason, you will be responsible for the payment of the entire balance due, based on our normal fee schedule. We accept cash, checks (with ID), as well as Visa, MasterCard, Care Credit, and debit cards for your convenience. All returned checks are subjected to a \$25 fee.

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to Alvernon Optical, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. **I acknowledge that prior authorization for services through my insurance company is not a guarantee of payment.**

I have read and understand the HIPPA and financial policies above.

Signature of client or authorized representative

Date

Print name of client

Print name of authorized representative

Thank you for placing your confidence in us and we hope you recommend us to a friend!