Dr. Paul Cinalli	Dr. Kenneth Lord	Dr. David Tetrault	Dr. Paula Peterson	Dr. Theresa Setlock	Dr. Sharon Peterson	Dr. Michael Shurtz	Dr. James Murphy
❒	❒	❒	❒	❒	❒	❒	❒

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? _____

Primary Insured: _____ Primary D.O.B. _____

Email Address: _____ Whom do we thank for referring you? _____

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

[ ] General annual exam (no specific problem)
[ ] Lost or broken eyeglasses
[ ] Want new eyeglasses
[ ] Want contact lenses - Currently wear C.L.
[ ] Want contact lenses - Never worn C.L.
[ ] Problem with present contact lenses
____ soft ____ rigid gas perm
____ disposable ____ tinted
____ toric ____ bifocal contact lenses

[ ] Blurred near vision
[ ] Blurred distance vision
[ ] See "spots" or flashes
[ ] Double vision
[ ] Light sensitivity
[ ] Eyes feel tired
[ ] Other (please list) _____
_____

[ ] Eyes water
[ ] Eyes itch
[ ] Eyes feel dry
[ ] Pain in eyes
[ ] Headaches

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:

[ ] Good general health
[ ] Heart disease
[ ] High blood pressure
[ ] Glaucoma
[ ] Allergies
[ ] Diabetes

[ ] Thyroid
[ ] HIV
[ ] Cataracts
[ ] "Lazy Eyes"
[ ] Eye surgery
[ ] Cancer

[ ] Retinal disorders
[ ] Eye injuries
[ ] Pain in eyes
[ ] Turned eye
[ ] Other (please list)
_____
_____

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). _____

_____

— OVER —

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 _____

HIPAA 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 HIPAA 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 HIPAA Privacy.

If you have any questions about your rights or our privacy practices, please feel free to ask to speak to our HIPAA 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 $35 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 that 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 HIPAA and financial policies above.

_____ _____
Signature of client or authorized representative Date

_____ _____
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!