Dr. Paul Cinalli	Dr. David Tetrault	Dr. Paula Peterson	Dr. Theresa Setlock	Dr. Sharon Peterson	Dr. Laura Schillig	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 (Circle One) Married_____ Single _____ Other _____

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). ____________________
____

Name ________________________________ **Date** ______________
Last First

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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!