Welcome To Our Office

Patient Name_____ Sex: M F Date: _____ Birth date_____

Brief Description if Yes

1. What is the reason for this visit? _____
2. Do we see any other family members? No Yes _____
3. Does the patient wear glasses or contact lenses? No Yes _____
4. Has the patient had an eye disease or eye surgery? No Yes _____
5. Has the patient had other hospitalizations? No Yes _____
6. Has the patient had:
   - Diabetes? No Yes _____
   - High blood pressure or high cholesterol? No Yes _____
   - Asthma or breathing problems? No Yes _____
   - Special testing (MRI, x-ray etc.) No Yes _____

7. Has the patient had a disease in the following areas?
   - Allergic/ Immunologic No Yes _____
   - Bones, Ligaments, Joints, Back No Yes _____
   - Ears, Nose, Mouth, Throat, Head No Yes _____
   - Endocrine (Hormones, Glands, Thyroid etc) No Yes _____
   - Gastrointestinal (stomach, Intestine) No Yes _____
   - Heart/ Blood Vessels / Stroke No Yes _____
   - Hematologic / Lymphatic (Blood disorders) No Yes _____
   - Neurologic (Brain, Nerves) No Yes _____
   - Oncologic (Cancers) No Yes _____
   - Psychiatric (Depression, Behavioral Problems) No Yes _____
   - Skin, Breasts, Hernias No Yes _____
   - Other No Yes _____

8. Medications (Please list current medications and reason for use)		Medication Allergies

9. Has any family member had any of the following conditions?

Condition	Father	Mother	Siblings	Other family members
Glasses Before age 40				
Glaucoma				
Amblyopia (lazy eye /strabismus-crossed eyes)				
Other eye disease				
Other significant disease (e.g. diabetes, stroke)				

10. For Adults Only

- Does the patient currently operate a motor vehicle?...N Y
- Does the patient currently live alone?..... N Y
- Does the patient currently use tobacco?..... N Y
  If yes, how many years?
- Has the patient ever used tobacco?..... N Y
  If yes, how many years?
- Does the patient drink alcohol?.....N Y
  If so, what frequency?___glasses every...day/week/month

11. For children under the age of 5 only

- Gestational age at birth (weeks)_____Birth weight_____
- Method of Delivery...C-section / Vaginal

Please describe any complications during pregnancy, delivery or after birth: _____

- If there is any history of developmental or scholastic delay, please describe: _____

Patient Information

Last Name: _____ **First Name:** _____ **MI:** ____ **Nickname:** _____

Title: (please circle one) Dr. Miss Mr. Mrs. Ms. Fr. Sr. **Suffix:** (please circle one) I II III JR MD DO DDS DC

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____

Daytime Phone: _____

Cell Phone: _____

We would like to occasionally communicate by texting. Will you permit texting? ☐ Yes ☐ No

Email Address (for office communication only): _____

Sex: M F **Birth Date:** _____ **SS#:** _____

Marital Status: Divorced Separated Single Widowed Married (Name of spouse) _____

Employment Status: (please circle one) Employed Student F/T P/T Self Employed Not Employed Retired

Employer: _____ **Occupation:** _____

Race: Declined to Specify ☐ American Indian/ Alaskan Indian ☐ Asian ☐

Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White ☐

Ethnicity: Declined to Specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐

Preferred Language: _____

How did you hear about our office? (please circle one) Patient Professional Referral Advertising Yellow Pages Insurance

Who referred you to our office? Patient/ Doctor Name _____

Primary Insurance

Insurance: _____ **Policy Holder's Name:** _____

Policy Group No: _____ **Copay:** _____ **ID#:** _____

Relationship to Insured: _____ **PPO/HMO:** _____ **Policy Holder's Employer:** _____

Policy Holder's SS# _____ **Policy Holder's DOB** _____

Secondary Insurance

Insurance: _____ **Policy Holder's Name:** _____

Policy Group No: _____ **Copay:** _____ **ID#:** _____

Relationship to Insured: _____ **PPO/HMO:** _____ **Policy Holder's Employer:** _____

Policy Holder's SS# _____ **Policy Holder's DOB** _____

Vision Insurance

Insurance: _____ **Policy Holder's Name:** _____

Policy Group No: _____ **Copay:** _____ **ID#:** _____

Relationship to Insured: _____ **PPO/HMO:** _____ **Policy Holder's Employer:** _____

Policy Holder's SS# _____ **Policy Holder's DOB** _____

North Shore Advanced Eye Care

Edward Moylan, OD - Julie DeMartini, OD - Justin Kraushaar, OD

Patient name: _____ Date: _____

I agree to be responsible for any fees that are not paid by my insurance or any other third party pay or for any of the following reasons:

- The insurance company deems the procedure(s) "uncovered, experimental" or "not medically necessary".
- The authorization is improper or the patient is ineligible for benefits on the date of service.
- My failure to provide a proper referral or correct insurance information prior to the visit.
- My failure to inform the office about existing insurance information prior to the visit.

Procedure	Fee
Ophthalmic Visit New/ Established	$110 / $105
Contact Lens Exam New/ Established	$165 / $160
Refraction	$55
Contact Lens Evaluation when Billed Separately	$55
Contact Lens Fitting/ Refitting	Fees Vary ($125-$250)
Retinal Photo	$40
Contact Lenses	Fees Vary
Dry Eye Testing/ Plugs	$100
OCT/ Visual Field	$125
Milia Removal	$175
Lipiflow Treatment	$595

Payment is due at the time service is rendered

I understand that this office cannot backdate any claim and wish to proceed with the outlined procedures(s) with full awareness that I am ultimately responsible for any claims not paid.

Signed: X_____ Date: _____
Relationship: _____

HIPAA policy acknowledgement.

I have read and fully understand this office's health information privacy practices.
Signed: X_____ Date: _____
Relationship: _____

If you wish to allow our office to provide anyone other than the patient or the patient's legal guardian access to the patient's protected health information, please request a form from the receptionist so we may modify your file.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO PERSON OTHER THAN PATIENT

PERSON(s) ALLOWED TO RECEIVE INFORMATION

Name _____
Relationship_____

Name _____
Relationship_____

I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ _____ _____
Patient Signature (Parent or Legal Guardian) Relationship if other than self Date