Hamden and Wallingford Eye Associates

Thank you for choosing our office to handle all of your eye care needs. In order to make this experience go as smoothly as possible, we are enclosing some paperwork to be completed prior to your scheduled appointment along with some information about what you can expect during your visit.

Attached you will find a front and back sided Patient Information form along with a Financial/HIPAA form. Please bring these to your appointment. If the patient is under 18 years of age, these forms must be completed and signed by an adult responsible for the minor.

ALL children under the age of 18 must be accompanied to the office by an adult who is responsible for their care. There are certain procedures or tests that could require consent along with issues from their exam, which may need to be discussed.

If you have a vision plan such as VSP, Davis Vision or Anthem Blue Vision, please alert us prior to your appointment so that we may obtain the appropriate authorization for your visit. Also bring your medical health insurance card so that we may complete your records in the event a non-routine procedure is required at this visit or in the future.

Contact lens services are not part of your annual examination. If you are a contact lens wearer, and a previous patient to our office, please be sure to wear your contact lenses so that they can be evaluated, unless you are experiencing any visual problems or discomfort wearing them. If you are a new patient to our office and in need of replacement contact lenses, please bring with you any information that you may have, such as the boxes, or a written prescription from your previous doctor's office, if available.

We provide a dilated retinal examination as part of your annual exam. This may blur your near vision for 1-2 hours and you will be light sensitive for 3-4 hours. Please bring your eyeglasses with you to your visit. We will supply you with a pair of sunglasses to wear home. If you do not feel comfortable driving, please bring someone along with you. If you do not wish to be dilated at the time of your exam, please discuss this with the doctor at that time. We can reschedule this portion of the exam for another time at no charge if it is performed within 1 month of the date of the exam.

If you have any further questions or concerns, please do not hesitate to call our office.

We look forward to seeing you soon.

Medical History – Hamden and Wallingford Eye Associates

Name:_____ Today's Date:____/___/_____ Birth Date:_____/_____/_____

Address:_____ Home Phone: _____Cell Phone:_____

_____Work Phone:_____ Last Eye Exam:____/___/_____

Name of Primary Care Physician::_____ PCP Phone:_____Last Medical Exam:___/___/_____

Occupation:_____Employer:_____Email:_____Last 4 Soc Security:_____

Primary Insurance Co:_____Insured:_____Relationship:_____

Insured's DOB: ____/___/_____ Insured's Last 4 of Soc.Secuity Number:_____

Secondary Insurance Co:_____Insured:_____Relationship:_____

Insured's DOB: ____/___/_____ Insured's Last 4 of Soc.Secuity Number:_____

How did you find our office?_____Emergency Contact:_____

MEDICAL HISTORY:

Do you have any allergies to medications? □ no □ yes (please list):_____

_____

List any medications you are currently taking (include OTC, birth control, vitamins:_____

_____

List major injuries, surgeries, or hospitalizations you have had:_____

_____

List any past eye problems you have had (lazy eye, patching, surgeries, glaucoma, infections, injuries):_____

Are you pregnant or nursing? □ no □ yes
Do you wear glasses? □ no □ yes How old is your current pair of lenses?_____
Do you wear contact lenses? □ no □ yes How old is the pair you are wearing today?_____
Type of contacts: □ soft □ hard/gas perm. □ hybrid Solution used:_____
How long have they been in today?_____ Average wearing time/day:_____ Replacement(circle): Daily 2week Monthly Traditional
Current lens age:_____ Over the last year have you had any days you could not wear your lenses due to pain or redness? □ no □ yes

FAMILY HISTORY

Please note any family history (parents, grandparents, children, siblings, living or deceased) for the following:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other	□	□	□	_____

**** Please turn over and complete the opposite side ****

SOCIAL HISTORY *This information is kept strictly confidential. You may discuss this directly with the doctor if you prefer.*

□ Yes, I would prefer to discuss my social history information directly with the doctor (check box)

Do you have difficulty driving □ no □ yes: please describe - _____

Do you use tobacco products? □ no □ yes If yes, type/amount/how long:_____

Do you drink alcohol? □ no □ yes If yes, type/amount/how long:_____

Do you use illegal drugs? □ no □ yes If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: □ gonorrhea □ hepatitis □ HIV □ syphilis

REVIEW OF SYSTEMS

Do you currently have or have you ever had problems in the following areas?

System	NO	YES	?
CONSTITUTIONAL			
Fever,Weight Loss/Gain	□	□	□
INTEGUMENTARY (Skin)	□	□	□
NEUROLOGICAL			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
EYES			
Loss of Vision	□	□	□
Blurred Vision	□	□	□
Distorted Vision/Halos	□	□	□
Double Vision	□	□	□
Drying	□	□	□
Mucous Discharge	□	□	□
Redness	□	□	□
Sandy/Gritty Feeling	□	□	□
Itching	□	□	□
Burning	□	□	□
Foreign Body Sensation	□	□	□
Exessive Tearing/Watering	□	□	□
Glare/Light Sensitivity	□	□	□
Eye Pain or Soreness	□	□	□
Chronic Eye or Lid Infections	□	□	□
Styes or Chalazion	□	□	□
Flashes/Floaters in Vision	□	□	□
Tired Eyes	□	□	□
ENDOCRINE			
Thyroid/Other Glands	□	□	□
Parathyroid/Pituitary	□	□	□

	NO	YES	?
EARS,NOSE,MOUTH, THROAT			
Allergies/Hay Fever	□	□	□
Chronic Sinus Congestion	□	□	□
Post-Nasal Drip	□	□	□
Chronic Cough	□	□	□
Dry Throat/Mouth	□	□	□
RESPIRATORY			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
VASCULAR/CARDIOVASCULAR			
Diabetes	□	□	□
Heart Pain	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
GASTROINTESTINAL			
Diarrhea/Constipation	□	□	□
Reflux	□	□	□
GENITOURINARY			
Genitals/Kidney/Bladder	□	□	□
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	□	□	□
Muscle Pain	□	□	□
Joint Pain	□	□	□
LYMPHATIC/HEMATOLOGIC			
Anemia	□	□	□
Bleeding Problems	□	□	□
ALLERGIC/IMMUNOLOGIC	□	□	□
PSYCHIATRIC	□	□	□

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

HAMDEN AND WALLINGFORD EYE ASSOCIATES

FINANCIAL RESPONSIBILITY:

1. I understand that it is my responsibility for payment for services and materials received at Hamden Eye Associates.
2. I am responsible for all co-payments, deductibles, and for the entire amount if my insurance company denies payment.
3. I understand that it is my responsibility to supply you with all information required to obtain payment from my insurance company (-ies) within 7 days of my service.
4. If a referral is required, I will obtain that referral as required by my insurance company. If payment is denied for lack of referral, I understand that payment is now my responsibility.
5. It is my responsibility to understand my insurance coverage and eligibility (with the exception of VSP and Davis Vision, which the office is responsible for obtaining).

Patient Initial: _____

SIGNATURE ON FILE:

1. I authorize release of information to all of my insurance companies.
2. I authorize my signature to be used on all insurance submissions.
3. I authorize my doctor and staff to act as my agent in helping obtain payment from my insurance companies.
4. I authorize payment to be paid directly to my doctor's office.

Patient Initial: _____

ACKNOWLEDGEMENT OF OFFER OF PRIVACY PRACTICES:

In providing service to you we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for our services, and to conduct healthcare operations involving our office. The NOTICE OF PRIVACY PRACTICES are available and describe these uses in more detail. Please do not hesitate to ask our staff for a copy.

Patient Initial: _____

I have read and understood all 3 sections noted above:

Patient Name: _____Signature_____

Date:_____ Witness:_____

We will be happy to provide you with a copy of this form upon request.