PATIENT INFORMATION (FORM UPDATED 10/09)
Elegance Optique • 1754 Sheridan Drive • Tonawanda, NY 14223

Name: _____ Gender M / F Date: _____ / _____ / _____

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

Date of Birth _____ / _____ / _____ Age: _____ Phone: (H) (_____)_____- _____ (W) (_____) _____ - _____

Email:_____Occupation:_____Hobbies:_____

Primary Care Physician: _____ Town: _____ Ph# (_____) _____ - _____

Health Insurance: _____Vision Plan: _____

Ocular (Eye) Symptoms: (Circle "*Y*" for Yes, "*N*" for No – and please answer each)

Itching	Y / N	Dryness	Y / N	Spots/Floaters	Y / N	Eye Strain	Y / N
Burning	Y / N	Discharge	Y / N	Flashing lights	Y / N	Pain in eye	Y / N
Redness	Y / N	Swelling	Y / N	Double vision	Y / N	Headache	Y / N
Blurred Vision	Y / N	Tearing	Y / N	Glare/Hallows	Y / N	Twitching	Y / N

Other:_____

Please answer the following questions about your medical status and history:

(Circle those that apply under question) *Please list anything additional and explain:*

Are you currently taking any medications, if so list them? . . . . . Y / N_____

_____

Have you ever had any eye disease, trauma or surgery? . . . . . Y / N_____
(glaucoma, cataract, macular degeneration, retinal detachment/disease, wandering or "lazy" eye, other)

Have you ever had any major injury, surgery or hospitalization? . . . .Y / N _____

Are you <u>*allergic*</u> to any medications?. . . . . .Y / N _____

Family History: (Please include parents, grandparents, aunts, uncles, siblings and children either living or deceased)

Any known medical diseases/conditions in your family? . . . . . .Y /N_____
(diabetes, hypertension, cancer, heart disease, kidney disease, arthritis, lupus, thyroid disease, other)

Any known eye diseases/conditions in your family? . . . . . .Y / N_____
(glaucoma, cataract, macular degeneration, wandering or "lazy" eye, blindness, retinal detachment/disease, other)

Social History: Do you smoke? Y / N How much/long?_____ Drink alcohol? Y / N How much/long? _____

Use illegal drugs? Y / N How much/long?_____ Infected with or exposed to HIV, hepatitis, syphilis, gonorrhea? Y / N

Review of Systems:

<u>*Do you currently or have you ever had any of the following problems?*</u> *Please circle all that apply and explain:*

Constitutional (fever, unexpected weight loss/gain, fatigue). . . . . .Y / N _____

Ear/Nose/Mouth/Throat (hearing loss, runny nose, sinus problems, sore throat, other).Y / N _____

Endocrine (thyroid, other glands) . . . . . .Y / N _____

Vascular/Cardiovascular (diabetes, heart, hypertension, vascular disease, cholesterol) ..Y / N _____

Respiratory (asthma, shortness of breath, bronchitis, emphysema, other) . . . . . .Y / N _____

Gastrointestinal (heartburn, diarrhea, constipation, vomiting, other) . . . . . .Y / N _____

Genitourinary (genitals, kidney, bladder) . . . . . Y / N _____

Integumentary (Skin) (rosacea, rashes, excessive dryness, other) . . . . . Y / N _____

Musculoskeletal (muscle aches, arthritis, joint paint, swollen joints, other) . . . . . Y / N _____

Lymphatic/Hematologic (anemia, bleeding problems, other) . . . . . Y / N _____

Allergic/Immunologic. . . . . Y / N _____

Neurological (numbness, weakness, headaches, seizures, paralysis, other) . . . . . Y / N _____

Psychiatric (depression, anxiety, other) . . . . . Y / N _____

CONTACT LENS PATIENTS

Do you wear or have you worn contact lenses? **Y / N** If not, are you <u>*interested*</u> in trying contact lenses? **Y / N**

Type of contacts worn: ❑ Soft ❑ Rigid-gas Perm (RGP)/Hard ❑ Astigmatic/Toric ❑ Bifocal ❑ Monovision ❑ Color

Brand of Contacts worn _____ Cleaning Solution Used _____

How often replaced? ____days____wks____mons____yrs Do you sleep in your contacts? **Y / N** _____

Please read and sign the following authorizations:

Authorization of Insurance Payments:
I hereby authorize payment of insurance benefits otherwise payable to me, directly to *Elegance Optique*.
In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees or collections services needed.

X ____ ______________________
Signature of patient (or parent if minor) Date

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Responsibility of Payment:
I hereby assume responsibility to pay the costs of all services provided by *Elegance Optique* to the patient.
I understand that I am financially responsible for any health insurance deductibles, copayments, and non-covered services.

X ____ ______________________
Signature of patient (or parent if minor) Date

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Acknowledgement of Receipt of Notice of Privacy Practices
In the course of 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, to obtain payment for our services, and to conduct healthcare operations involving our office.
The Notice of Privacy Practices you have been offered describes these uses and disclosures in detail.
Please sign below to acknowledge that you are aware of the Notice of Privacy Policies from *Elegance Optique*.

X ____ ______________________
Signature of patient (or parent if minor) Date

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FOR ALL Contact Lens Patients

Acknowledgement of Contact Lens Fitting / Evaluation / Management Policies
There is a separate professional fee (*not included in the eye exam fee*) for all additional tests, measurements and follow-up care involved in the successful fitting, evaluation & management of any type of contact lenses.
Generally, this fee ranges from $24-$70 depending on the “complexity of the fit” and the “amount of professional time” needed to complete the process. This fee is not covered under most insurance plans, and is therefore, your responsibility to pay at the time of services.
Our goal is to provide you with those contact lenses which are best suited to your particular needs and will result in the best comfort, vision and eye health.

X ____ ______________________
Signature of patient (or parent if minor) Date