



Patient Information

First Name: _____ **Middle:** _____ **Last Name:** _____ **Suffix:** _____

Nickname: _____

Title (circle one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

Date of Birth: _____

Mailing Address:

Phone # you would like us to call 1st: _____

Phone # you would like us to call 2nd: _____

Email address: _____

How would you like us to contact you?(check one) Phone Email Text

Employment Status (circle one)

Employed FT Student Other Retired Self-employed

Occupation: _____

Hobbies/Interests:

How did you hear about our office?

Insurance Authorization and Assignment

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Vitelli Eye Care, LLC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that the photocopy of this agreement shall be as valid as the original and that I have read and understand the contents thereof.

If you have Medicare for your insurance, only those procedures that can be billed with a medical code are covered. The diagnostic procedure the doctor uses to determine your eyeglass prescription is a routine procedure known as a "refraction." Medicare requires this procedure to be billed to them but they do not cover it because it is a routine procedure. The refraction fee of \$40.00 and is due and payable on the date of your exam.

In addition to your medical insurance which may or may not cover a routine eye exam, **do you have separate vision insurance which covers your eye examinations and possibly materials? (circle one) Yes No**

NOTE: Separate vision insurance needs to be revealed at the time of your exam as billing is done on the same day that you are seen and can not be redone once submitted.

Please sign that you have read and agree to the above: _____ Date: _____



Patient Information

For Contact Lens Wearers: Your Annual Contact Lens Evaluation

Contact lenses are medical devices that can cause serious consequences, such as infection, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise for which most insurance companies do not reimburse. For that reason, there are separate, additional charges for contact lens examinations that patients without contact lenses do not pay. Dr. Vitelli must verify that your eyes are responding well to contact lens wear, check the ocular surface for any adverse reactions and make sure the lenses are fitting properly and are the correct prescription for your eyes. This type of examination is necessary if you wish to continue wearing contacts. Once finalized, per MA state regulations, your prescription is valid for up to 1 year. This means you can purchase enough lenses to last for 12 months and no more. After 12 months, the prescription expires. Dr. Vitelli will not renew expired prescriptions without first making sure that your eyes are healthy enough to wear lenses. To avoid any inconvenience, make sure your annual examination is scheduled on time so that you do not run out of lenses before you are seen. If you wear contact lenses, this examination must be done annually, even if your insurance only allows for a 2-year examination interval. If for some reason, you require additional time or visits because there has been a change in the type of lenses you wear, there may be additional refitting fees. These cover any additional examination time and follow-up appointments that may be necessary to finalize a refit into another type of contact lens.

The cost for the annual contact lens evaluation for is \$65.00

Please sign that you have read and agree to the above: _____ Date: _____

For Patients under the age of 18:

Guarantor Name: _____ Date of Birth: _____

Mailing Address (if different than patient):

Primary Telephone: _____ Secondary Telephone: _____

Relationship to Patient: _____



Medical History Questionnaire

Date: _____ / _____ / _____

Medical Doctor: _____

Medical Doctor's address and phone number: _____

Medications (including over the counter and vitamins): _____

Allergies (both environmental and to medications): _____

Do you smoke? Previous smoker? Packs per day? _____

Medical History: Do you currently, or have you ever had problems in the past with the following areas:

EYES: Conditions, Disease, Lazy or crossed, Surgery, Other _____

Constitutional Symptoms: Fever, Weight Loss/Gain, Other _____

Integumentary: Skin problems, Other _____

Neurological: Headaches, Seizures, Other _____

Endocrine: Thyroid, Diabetes, Other _____

Ears, Nose and Throat: Allergies, Sinus Problems, Other _____

Respiratory: Asthma, COPD, Other _____

Cardiovascular: High Blood Pressure, High Cholesterol, Other _____

Gastrointestinal: Gastric reflux, Other _____

Musculoskeletal: Arthritis, Muscle pain, Joint Pain, Other _____

Lymphatic/Hematologic: Anemia, Bleeding problems, Other _____

Allergic/Immunologic: Auto-immune, Other _____

Psychiatric: Depression, Anxiety, Other _____

Are you currently pregnant or breast feeding?

Family History:

Condition	No/Yes	Relationship to you
Blindness	_____	_____
Glaucoma	_____	_____
Mac Degeneration	_____	_____
Retinal Disease	_____	_____
Crossed/Lazy eyes	_____	_____
Diabetes	_____	_____
Other	_____	_____



The Difference between Health/Medical and Routine/Vision Insurance

Periodic eye exams are important to maintain clear vision and healthy eyes throughout your lifetime. It is important that you understand your insurance benefits and how they apply to your visit. This sheet will help you understand how your visit will be submitted to your health insurance or vision plan. Benefits may vary based upon the reason for your visit, and your individual health insurance or vision plan.

Routine Eye Examinations:

A “routine” eye exam is performed to check the eye for visual deficiencies that would require glasses or contacts and to screen the eye for possible disease. It does not normally include a dilated retinal exam. This type of exam is covered by your Routine Coverage/Vision Insurance Plan.

Examples include:

- Exam for new eyeglasses
- Exam for new contact lenses

Medical Eye Examinations:

Medical eye exams are for evaluation of a medical related complaint or follow up of an existing ocular condition found in a previous routine exam. Depending on the condition, dilation is often performed. This type of exam is billed to your Health/Medical Insurance Plan. Medical plans generally do not pay for the “refraction” (eyeglass prescription determination test) and you may be required to pay for this test.

Examples that necessitate your visit being billed as a medical exam include but are not limited to:

- Diabetes Mellitus
- Floaters and or flashing lights
- Dry, Red, Allergic, Irritated, or Infection
- Glaucoma
- Macular Degeneration
- Cataracts
- Certain high risk medications

If the doctor determines that your problem or exam falls under the category of a “medical eye exam,” your visit may be billed as a medical exam instead of a routine exam, and will be subject to co-pays and deductibles according to your medical insurance plan.

Signature

_____/_____/_____
Date