Medical History Questionnaire Today's Date: _____

First Name Middle Initial Last Name Nickname/Preferred Name

What is the reason for today's eye exam?

_____

Referred to us by: ❑ Insurance Plan ❑ Hospital ❑ Internet/Google

❑ Doctor: _____ ❑ Family/Friend: _____

Please tell us about your medical history:

Do/did you have:	Yes	No	Does anyone in your family have:	Yes	No
Cataracts	❑	❑	Cataracts	❑	❑
Glaucoma	❑	❑	Glaucoma	❑	❑
Retinal disease	❑	❑	Retinal disease	❑	❑
Diabetes	❑	❑	Lazy eye/amblyopia	❑	❑
Eye/eyelid surgery	❑	❑	Eye/eyelid surgery	❑	❑

If you are a new patient and answered Yes to any of the above, please tell us more (e.g. if you had eye surgery, what kind and when?):

_____

_____

Do/did you have:	Yes	No	Do/did you have:	Yes	No
Heart disease	❑	❑	Urinary problems	❑	❑
High blood pressure	❑	❑	Arthritis	❑	❑
Lung disease	❑	❑	Skin problems	❑	❑
GI disease	❑	❑	Neurological disease	❑	❑
Ear/Nose/Throat disease	❑	❑	Cancer	❑	❑
Psychiatric disorder	❑	❑	Thyroid disease	❑	❑

Do you:	Yes	No
Smoke	❑	❑
Drink alcohol	❑	❑

If you are a new patient and answered Yes to any of the above, please tell us more. If you are an existing patient, please update us on any new changes:

_____

_____

_____

Do you have any allergies? If yes, please provide details (e.g. Penicillin – causes hives).

❑ No ❑ Yes _____

List medications & supplements. Include dose & how often (if you have a list, we can photocopy it):

_____

_____

_____

For Office Use

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Registration Form – Greenwich Ophthalmology Associates

General Information Today's Date: _____

First Name | Middle Initial | Last Name | Name of Your Primary Care Doctor

Date of Birth | Social Security # | Email Address | ❑ Male ❑ Female

Home Phone Number | Cell Phone Number | Daytime Phone (if different)

Home Address

City | State | Zip Code

Employment Status: ❑ Employed ❑ Retired ❑ Student (full-time)

Preferred Pharmacy (please include address and/or phone number, if known)

Insurance Information

Primary Insurance Company | Policy/Member ID Number | Group Number

Secondary Insurance Company | Policy/Member ID Number | Group Number

Billing Information

❑ If billing information is the same as above, check here. ONLY if billing information is different, fill out the form below.

First Name | Middle Initial | Last Name | Relationship to Patient

Date of Birth | Social Security # | Email Address | ❑ Male ❑ Female

Home Phone Number | Cell Phone Number | Daytime Phone (if different)

Billing Address

City | State | Zip Code

Insurance/Managed Care Billing Waiver

Below is an outline of our managed care policies. We hope that clear communication will help alleviate some of the inconsistencies and incongruous policies the managed care companies have placed on their members.

Greenwich Ophthalmology Associates, PC • Fairfield County Laser Vision, LLC will make every effort to collect from your insurance plan. With all of the varieties of coverage available, it would be impossible for this office to know each plan or inquire for each patient.

Payment is required at the time of service for the following:

- All co-pay amounts
- Refraction: not covered by Medicare or most managed care plans
- Contact lens check: evaluation done to determine fit & prescription
- All contact lenses and fittings done by the optometrist or contact lens technician
- Optomap imaging: this test may be offered instead of dilating drops. This is not covered by insurance. The fee is due on the day of service if you choose to have it performed.

You will be balance billed for:

- Deductibles and co-insurances
- Fees for services that were denied due to failure to obtain a referral
- Any service denied by your plan that is billable within the guidelines of the managed care system.

I agree to pay for the services rendered by my physician at Greenwich Ophthalmology Associates, PC • Fairfield County Laser Vision, LLC if my insurance company denies coverage. I authorize you to release any information to my insurance company for the purpose of processing claims; this includes any HIV information.

Signature: _____ Date: _____
patient or legal guardian

Print Name: _____

Medicare Waiver (sign ONLY if Medicare is your insurance provider):
I understand that Medicare considers a routine exam and refraction as a "non-covered" procedure. I understand that I am responsible for payment in full for these procedures at today's visit. I also understand that Medicare does not consider Optomap testing a covered procedure. If my physician feels it necessary for me to have this test I will be responsible for that fee today, as well. I authorize Greenwich Ophthalmology Associates, PC • Fairfield County Laser Vision, LLC to release any information to Medicare for the purpose of processing claims; this includes any HIV information.

Signature: _____ Date: _____
patient or legal guardian

Print Name: _____

HIPAA Acknowledgment (everyone must sign):
I acknowledge that I have been provided with a copy Greenwich Ophthalmology Associates, PC • Fairfield County Laser Vision, LLC privacy notice.

Signature: _____ Date: _____
patient or legal guardian

Print Name: _____