Vision Source

Today's Date_____

CONSUMER OPTICAL

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer **ALL** questions.

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Daytime Phone_____ Home Phone_____ Cell Phone_____

Date of Birth_____ Occupation_____ Employer_____

Emergency Contact Name_____ Phone Number_____

Date of Last Eye Exam_____ Dilated? Yes No Referred By_____

Primary Vision Coverage_____ Secondary Coverage_____

MEDICAL INFORMATION

What is your general health?_____

Do you have problems with any of these systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (Glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscle/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (Skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please Explain:_____

Diabetes Yes/No Type _____ Date of Diagnosis _____

Allergies To Medications Yes/No Which?_____ Reactions?_____

Other Health Problems_____

Current Medication(s)_____

Have you had any operations? Yes/No Kind?_____ When?_____

Name of family doctor_____

Date of Last Visit_____ Date of Last Tetnus Shot_____

Family History

High Blood Pressure	Yes/No	Relation_____	Macular Degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal Detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye operations? Yes/No Type_____ Date_____

Have you had an eye injury? Yes/No Kind_____ Date_____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular Degeneration? Yes/No Retinal Detachment? Yes/No Blurred Vision? Yes/No

Do you wear glasses? Yes/No Contact Lenses? Yes/No Type_____

Additional Information_____

Doctor Use Only

Reviewed By_____ Changes Yes/No Date_____

Reviewed By_____ Changes Yes/No Date_____

Reviewed By_____ Changes Yes/No Date_____

VISION SOURCE®
CONSUMER OPTICAL
Albert Morier, M.A., O.D. & Associates
1426 Altamont Avenue
Rotterdam, NY 12303
P: 518-355-0795 | F: 518-355-1208
www.consumeroptical.com

Patient Responsibility Statement

( ) I have insurance coverage, and authorize direct payment from my insurance carrier to Consumer Optical Co. Inc.

*You are responsible for knowing your coverage benefits at the time of service. If there are any changes to your insurance, please let us know immediately so we can submit your claim properly.

Optical Insurance Plan_____

Medical Insurance Plan_____

(Please present insurance card(s) and/or forms to receptionist at arrival)

( ) I do not have insurance coverage and understand that I am responsible for payment of all charges.

I understand that if my eligibility cannot be verified or my coverage has been terminated before my date of service, I will be financially responsible for payment of all charges incurred for my services received at Consumer Optical.

Patient:_____Date:_____

Parent/Guardian(if minor):_____ Date:_____

We also offer Care Credit® no interest monthly payment finance as an alternative to credit cards (application and online approval available in minutes at our office).

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PATIENT CONSENT FORM

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- conduct normal health care operations such as quality assessments and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____(print)

Signature:_____ Date:_____

Relationship to patient:_____

Optomap Retinal Imaging

We now have the latest in retinal imaging computerized cameras, the Optos California. This allows us to provide you with a very thorough analysis of your retina WITHOUT HAVING TO GET A FEW INCHES FROM YOUR EYES! This is a wonderful ability but even more important in these times of COVID-19. In most cases, it is not necessary to be dilated as well.

We encourage ALL of our patients to elect to have this evaluation. We have reduced the normal charge for this from $39 to $25 (includes both eyes). If there is a medical issue, your insurance may cover the cost.

I cannot express to you how marvelous this technology is and how many conditions such a retinal hemorrhaging, retinal tears/ holes, nevi, etc. we have found since procuring this instrument.

Albert M. Morier, O.D., M.A. and Associates

Please check one:
_____ I would like the retinal photography done.
_____ I would like to discuss it with the doctor first

Patient signature:_____
Parent/ Guardian (if minor)_____
Date:_____