SVC Medical History Questionnaire

Date: / /

Name ________________________________ Phone ______________ Birth Date____/____/______
Address ____ Soc. Sec. # ______-_____-_________
City _____________________ State ________ Zip __________Last Eye Exam ______/_______/_______
Medical Doctor ____________________________________ Dr.'s Phone _____________________
Insurance Company ___________________ ☐ Vision ☐ Medical Last Medical Exam _____/____/______
Are you allergic to any medications? ☐ No ☐ Yes If yes, explain ______________________________
____

List the medications you take (including oral contraceptives, aspirin, and over the counter medications)
____
____
____

List major injuries, surgeries, and/or hospitalizations ____
____

Have you had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? ____
Are you pregnant and/or nursing? ☐ no ☐ yes ____
Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _________________
Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? ____________
Type of contact lenses? ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are they comfortable? ☐ no ☐ yes
Have you had, or are you interested in Laser Vision Correction? _______________________________
List hobbies/activities with special visual demands? ____

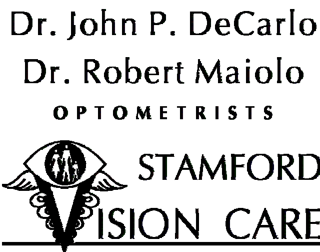
Family History Please note family history (parents, grandparents, siblings, children, living or deceased):

	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	____________________
Cataract	☐	☐	☐	____________________
Crossed Eyes	☐	☐	☐	____________________
Glaucoma	☐	☐	☐	____________________
Macular Degeneration	☐	☐	☐	____________________
Retinal Detachment/Disease	☐	☐	☐	____________________
Arthritis	☐	☐	☐	____________________
Cancer	☐	☐	☐	____________________
Diabetes	☐	☐	☐	____________________
Heart Disease	☐	☐	☐	____________________
High Blood Pressure	☐	☐	☐	____________________
Kidney Disease	☐	☐	☐	____________________
Lupis	☐	☐	☐	____________________
Thyroid Disease	☐	☐	☐	____________________
Other ______________	☐	☐	☐	____________________

Hepatitis ☐ Lymes ☐ Gonorrhea ☐ HIV ☐ Syphilis ☐

Confidential Social History ☐ I would prefer to discuss my Social History directly with my doctor.
Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long? _____________________
Do you drink alcohol ? ☐ no ☐ yes Other substances? ☐ no ☐ yes: _________________________
Do you drive? ☐ no ☐ yes If yes, do you have and difficulty when driving? ☐ no ☐ yes If yes, please describe: ____

Dr. John P. DeCarlo
Dr. Robert Maiolo
OPTOMETRISTS



Receipt of Notice of Privacy Policies & Consent Form
Insurance Responsibility Consent Form

Patient Name: ____

Patient Number: _______ Patient Phone Number: ______________________

Patient Address: ____

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 health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office or at www.stamfordvisioncare.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Stamford Vision Care, LLC.

______________________________ ____________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________ ______________________________
Relationship to Patient Print Name

Source of Authority: ____

I certify that the insurance information provided by me is accurate. I authorize the use of this information in helping me obtain payment for the services provided to me. I authorize payment directly to my doctor. A copy of this authorization may be used in place of the original.

I understand that the accuracy of this information is my responsibility. I also acknowledge that all fees for services and materials provided to me are my responsibility. I agree to pay all fees for services or materials should my insurance company reject the claim for any reason.

Medicare pays for 80% of **covered** services, but does not pay routine vision examinations or the refraction portion of any eye examination. In addition, some ancillary testing may not be covered. Medicare does not pay for frames or lenses except a portion of the first pair after cataract surgery. By law Stamford Vision Care, LLC is obligated to collect the remaining 20%, unmet deductibles, and amounts for uncovered services.

Signature: Date:

526 Newfield Avenue Stamford, Connecticut 06905 (203) 327-1511 FAX: (203) 325-4479
stamfordvisioncare.com