AIDONE EYECARE

PATIENT FORM

Today's Date ___/___/____

GENERAL INFORMATION

Patient's Name:

D.O.B.; _____/_____/_____

Male/Female

Address:

City/State/Zip:

Preferred Phone #: Home Cell Work

Secondary Phone #: Home Cell Work

Marital Status: _____ Occupation: _____

INSURANCE INFORMATION

Vision Insurance:

Vision Insurance Member Name:

Vision Insurance Member ID#/Group #:

Vision Insurance Member Date of Birth:

Primary Medical Insurance:

Primary Member Name:

Insurance ID#/Group #:

Primary Member Date of Birth:

Your Relationship to Primary Member: self/spouse/ child

PATIENT FORM- Medical History

EYE HISTORY

APPROX. DATE OF LAST EYE EXAM: ____/____/____

DO YOU WEAR CONTACT LENSES? Y / N

REASON FOR TODAY'S VISIT:

HAVE YOU OR A FAMILY MEMBER EXPERIENCED, OR HAVE BEEN TREATED FOR, ANY OF THE FOLLOWING?

CATARACTS	YES	NO	FAMILY
CROSSED EYE	YES	NO	FAMILY
DIABETIC RETINOPATHY	YES	NO	FAMILY
GLAUCOMA	YES	NO	FAMILY
LASIK	YES	NO	FAMILY
LAZY EYE	YES	NO	FAMILY
MACULAR DEGENERATION	YES	NO	FAMILY
RETINAL DETACHMENT	YES	NO	FAMILY

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

- ☐ BLURRED OR DECREASED VISION
- ☐ DOUBLE VISION
- ☐ DRYNESS
- ☐ EXCESS TEARING/WATERING
- ☐ EYE PAIN OR SORENESS
- ☐ FLOATERS OR SPOTS
- ☐ HALOS
- ☐ HEADACHES
- ☐ ITCHING
- ☐ LIGHT FLASHES
- ☐ LIGHT SENSITIVITY
- ☐ TROUBLE READING
- ☐ OTHER (PLEASE SPECIFY) _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

APPROX. DATE OF LAST PHYSICAL: ____/____/____

CURRENT MEDICATIONS AND SUPPLEMENTS:

HAVE YOU OR A FAMILY MEMBER EXPERIENCED, OR HAVE BEEN TREATED FOR, ANY OF THE FOLLOWING?

DIABETES	YES	NO	FAMILY
HIGH BLOOD PRESSURE	YES	NO	FAMILY
HIGH CHOLESTEROL	YES	NO	FAMILY
ARTHRITIS/JOINT OR MUSCLE PAIN	YES	NO	FAMILY
ANY NEUROLOGICAL ISSUE	YES	NO	FAMILY
ANY PSYCHIATRIC CONDITION	YES	NO	FAMILY
ANYTHING NOT LISTED	YES	NO	FAMILY

IF YES TO ANY OF THE ABOVE, PLEASE SPECIFY:

ANY MEDICATION OR DRUG ALLERGIES?

ARE YOU PREGNANT OR NURSING? Y / N

DO YOU SMOKE? Y / N

HAVE YOU EVER SMOKED? Y / N

AIDONE EYECARE
3630 STATE ROUTE 245
COBLESKILL, NY 12043
518-234-2020

NOTICE OF PRIVACY PRACTICES

Effective April 14th, 2003, this office will comply with new federal regulations intended to protect the privacy of patients' health information. The new regulations are in addition to state law, which in some instances are stricter than the federal requirements.

The law requires us to provide you with this notice, and therefore, we need you to acknowledge that you have received it. In addition, in order for us to continue to treat you, receive payment for services, and run our optical practice, we need you to provide us with a general written consent. This consent gives us permission to share your health information with other providers including specialists, primary care doctors, and surgeons involved in treating you; as well as with your insurance company and other business associates of the practice. Generally, you will be informed before your information is released.

As has always been our policy, our procedures are designed to show respect for patient privacy. We appreciate your consideration with regard to signing this form.

By signing below, I hereby acknowledge that I am aware of patient privacy laws and that my health information will be protected as designated under such laws. I hereby consent to the use and disclosure of my health information for the treatment purposes, payment activities, and health care operations of this office.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____
Print name of Patient or Personal Representative

AIDONE EYECARE
3630 STATE ROUTE 245
COBLESKILL, NY 12043
518-234-2020

FINANCIAL DISCLOSURE

I understand that if I am using insurance today, that it must be presented to the staff of Aidone Eyecare on the same day as services provided.

Furthermore, I understand that Aidone Eyecare will be billing my insurance company for services rendered. If for **any reason** my insurance company does not pay Aidone Eyecare for such services, I agree to pay Aidone Eyecare in full for any and all services rendered.

Aidone Eyecare does not guarantee insurance coverage for any service provided. Any question regarding insurance coverage should be directed to your insurance company.

_____ ____/____/____
Signature of Patient or Personal Representative Date

CANCELLATION/NO SHOW POLICY

Thank you for choosing Aidone Eyecare for your vision care needs. We appreciate the opportunity to be your eye care provider.

If you are unable to keep your appointment, please contact our office at (518) 234-2020 at least 24 hours prior to your scheduled appointment time. We reserve the right to charge a fee for same day cancellations or no-show appointments according to our policy as follows:

The FIRST no-show or same day cancellation is no charge as a courtesy to our patients. We will call you to reschedule the appointment.

The SECOND no-show or same day cancellation will result in a $50 fee, which must be paid prior to making further appointments.

The THIRD no-show or same day cancellation, you will be discharged from the practice.

We value your time, and appreciate you valuing ours as well. If you have any questions, please do not hesitate to contact us. We appreciate you choosing Aidone Eyecare for your eye care needs.

_____ ____/____/____
Signature of Patient or Personal Representative Date