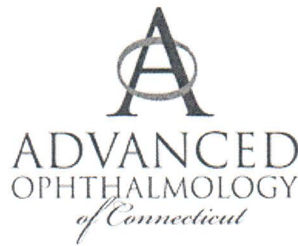
Old Greenwich
1455 East Putnam Ave
Old Greenwich, CT 06870
www.TheEyeMDs.net
(203) 348-7575
(203) 348-2893 Fax



Patient In-Take Form

Social Security # _______-_______-________ Today's Date: _______________

Patients Full Name: ________________________________ Date Of Birth: _______________

Are you: ○ Female ○ Male | Are you: ○ Single ○ Married ○ Divorced ○ Widowed

Home Address: ____

City: ________________________ State: ______________ Zip Code: __________________

Home #:___________________ Cell #: ____________________ Work #: _________________

Employment Status: ○ Retired ○ Employed: ____
Where do you work?

○ Student: ____
What school? What Grade?

Referring Physician: ____
Doctors Name, Doctors Phone # & Fax #

Primary Care Physician: ____
Doctors Name, Doctors Phone # & Fax #

Do You Smoke: ○ Yes ○ No

Ethnicity:___________________ Language: _______________________ Race: _________________

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 billow.

Full Name: ________________________________ Relationship To Patient: _________________
Home Address: ____
City: ________________________ State: ______________ Zip Code: ____________________
Home #:___________________ Cell #: ____________________ Work #: ___________________

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**
Cataracts	❑	❑
Glaucoma	❑	❑
Retinal disease	❑	❑
Diabetes	❑	❑
Eye/eyelid surgery	❑	❑

Does anyone in your family have:	**Yes**	**No**
Cataracts	❑	❑
Glaucoma	❑	❑
Retinal disease	❑	❑
Lazy eye/amblyopia	❑	❑
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**
Heart disease	❑	❑
High blood pressure	❑	❑
Lung disease	❑	❑
GI disease	❑	❑
Ear/Nose/Throat disease	❑	❑
Psychiatric disorder	❑	❑

Do/did you have:	**Yes**	**No**
Urinary problems	❑	❑
Arthritis	❑	❑
Skin problems	❑	❑
Neurological disease	❑	❑
Cancer	❑	❑
Thyroid disease	❑	❑

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

For Office Use

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

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 ____

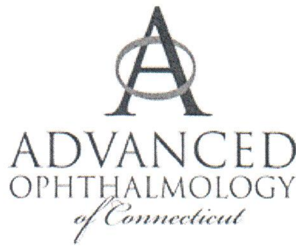
List medications & supplements. Include dose & how often (if you have a list, we can photocopy it):

____

____

____

Old Greenwich
1455 East Putnam Ave
Old Greenwich, CT 06870
www.TheEyeMDs.net
(203) 348-7575
(203) 348-2893 Fax



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. Advanced Ophthalmology of Connecticut 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, Deductibles that have not been met & co-insurances.
- Refraction ($55.00) NOT covered by Medicare or most managed care plans.
- All Contact lenses fitting ($200.00) & updates ($75.00) Evaluation done to determine fit and prescription.

You will be billed for the following:

- Fees for services that were denied due to failure to obtain a referral.
- Any Services 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 Advanced Ophthalmology of Connecticut if my insurance company denies coverage. I authorize you to release any information to my insurance company for the purpose of processing claims; this included any medical information.

Signature: ______________________________ Date: ____________________
Patient or Legal Guardian

Print Name: ______________________________

Medicare **Waiver (sign ONLY if Medicare/Medicare HMO 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. If you have enrolled in a Medicare HMO, it is your responsibility to inform the staff and remit your Co-pay and Deductibles at the time of service. I authorize Advanced Ophthalmology of Connecticut to release any information to Medicare for the purpose of processing claims; this included any medical Information.

Signature: ______________________________ Date: ____________________
Patient or Legal Guardian

Print Name: ______________________________

HIPAA Acknowledgment (everyone must sign):
I acknowledge that I have been provided with a copy of Advanced Ophthalmology of Connecticut privacy notice

Signature: ______________________________ Date: ____________________
Patient or Legal Guardian

Print Name: ______________________________