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

ADVANCED
OPHTHALMOLOGY
of Connecticut

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?

_____

For Office Use

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):

_____

_____

_____

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ADVANCED OPHTHALMOLOGY of Connecticut

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 ($69.00) NOT covered by Medicare or most managed care plans.
- All Contact lenses fitting ($250.00) & updates ($95.00 - $105.00) 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: _____