Pugliese Family Eye Care

41 Sanderson Road Suite 203
Smithfield, RI 02917
401-349-4791

Please answer all questions:

Last Name:_____ First Name:_____ MI: ____ Jr./Sr./II/III

Street: _____ City: _____ State: ____ Zip: _____

Phone: (Home) _____ (Cell) _____ SS# ____/____/____

Email Address _____@_____ May we contact you by email: Yes / No

Occupation: _____ Employer: _____

Emergency Contact / Telephone Number: _____

Date of last eye exam: ____/____/____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Medical Information

What is your general health: _____ Are you pregnant yes / no

Do you have problems with any of these systems?(please circle all that apply) Eyes Yes / No

Gastrointestinal	Yes / No	Nervous	Yes / No	Mental	Yes / No
Ears/Nose/Throat	Yes / No	Genitourinary	Yes / No	Endocrine (glands)	Yes / No
Cardiovascular	Yes / No	Musculoskeletal	Yes / No	Blood / Lymph	Yes / No
Respiratory	Yes / No	Integumentary (Skin)	Yes / No	Allergic / Immunologic	Yes / No

Please explain: _____

Diabetes: Yes / No Type: _____ Date of Diagnosis: ____/____/____

Allergies: Yes / No Seasonal: Yes / No Itchy Eyes: Yes / No

Headaches: Yes / No Other health problems: _____

Have you had any operations? Yes / No Kind? _____ Date: ____/____/____

Name of family doctor: _____ (Phone)_____ (Fax)_____

Family History

High blood pressure: Yes / No Relation: _____ Diabetes: Yes / No Relation: _____

Macular degeneration: Yes / No Relation: _____ Glaucoma: Yes / No Relation: _____

Retinal detachment: Yes / No Relation: _____ Cataract: Yes / No Relation: _____

Other eye condition(s) Yes / No Type: _____ Relation: _____

Personal Eye Information

Have you had any eye operations? Yes / No Type: _____ Date: ____/____/____

Have you had an eye injury? Yes / No Type: _____ Date: ____/____/____

Do you Have glaucoma? Yes / No Cataract? Yes / No Dry Eye: Yes / No Blurred vision: Yes / No

Other eye problems? Yes / No Type: _____

Do you wear glasses? Yes / No Contact lenses? Yes / No Type: _____

Additional information

_____

_____

_____

Whom may we thank for referring you? _____

Doctor's initials: _____

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The Following questions are part on the government Meaningful Use program. All information is collect anonymously. No contact information will be shared with any third party businesses.

Race:_____ Ethnicity:_____
Preferred Language:_____ Communication Preference: Email / Postal / Telephone

Tobacco Use
- ☐ Never Smoked ☐ Current Everyday Smoker ☐ Current Smokeless Tobacco User
- ☐ Former Smoker: Stopped Smoking ☐ Within 1 year ☐ 1-2 Yrs ☐ 4-5 Yrs ☐ 3-4 Yrs ☐ 5+ Yrs ☐ 10+ Yrs

Alcohol Use
- ☐ None ☐ 1-2 Drinks Daily ☐ Alcohol Dependence ☐ Social Use ☐ Above Average

Narcotics
- ☐ None ☐ Recreational Use ☐ Chemical Dependence

Sexually Transmitted Disease
- ☐ None
- ☐ Yes:_____
- ☐ HIV Positive

Blood Transfusion
- ☐ None
- ☐ Yes
- ☐ HIV Positive

Birth Order
- ☐ 1st ☐ 4th ☐ Only Child
- ☐ 2nd ☐ 5th ☐ Identical Twin
- ☐ 3rd ☐ > 5th ☐ Fraternal Twin

Height: _____ Weight: _____ Blood Pressure: _____

Medications

Name:	Reason for taking:	Dosage:

Drug Allergies

Name:	Reaction:

Pugliese Family Eye Care

John R. Pugliese OD

41 Sanderson Rd Suite 203
Smithfield, RI 02917
Phone: 401-349-4791
Fax: 401-349-4795

Office Policies

So that you do not incur unexpected and or unnecessary costs for your medical care, we would like to inform you of our office policies. Many of these policies have been established due to insurance regulations.

1. Co-payments are due at the time of your visit. We accept cash, checks and credit card payments for your convenience. Medicare is accepted, however, a co-payment is required unless you have a secondary insurance.
2. Medicare and many insurance companies do not cover refractions.
3. The refraction is the part of the exam that determines the need for your proper eyeglass prescription. Our office fee for refraction is $35.00 and is due at the time of the visit.
4. We participate in many managed care plans, however, it is your responsibility to verify coverage of benefits with your insurance company prior to your visit.
5. We will be happy to process your claim with your insurance company(ies), provided we have accurate and complete information.
6. You are responsible for any charges incurred as a result of your visit. If your insurance company fails to pay your bill within 90 days, the bill may be transferred to you.
7. If you fail to make prior arrangements with us, your account balance may be turned over to a collection agency.
8. If you have no insurance, payment is expected at the time of service.
9. There will be a $25.00 charge for checks returned due to insufficient funds.
10. Special evaluation and assessment of contact lenses is not a part of a standard eye examination. Our fee begins at $45.00 for this evaluation and is dependent upon the specialty of the contact lens involved.
11. Your account will be charged $25.00 for missed appointment without 24 hour notice.

We make every effort to deliver excellent eye care. Health care insurance is often complex and we believe a clear understanding of our mutual responsibilities will help us in this effort. Please ask if you have any questions about our office policies. We appreciate your input and will be happy to assist you.

I hereby acknowledge having read, understood, and received a copy of Pugliese Family Eye Care's Office Policies.

_____ _____

Signature Date

Pugliese Family Eye Care

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Receipt of Notice of Privacy Policies & 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.

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 Pugliese Family Eye Care.

_____ _____
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: _____