## PATIENT HISTORY QUESTIONNAIRE

DATE__________

PLEASE ANSWER ALL QUESTIONS.

Last Name ________________________ First Name ____________________________

Address ______________________ City _______________________ State ______

Zip ____________ Email _________________________ Date of Birth ___________

Home phone ____________ Work phone _____________ Cell _______________

Occupation _____________________ Employer ___________________________

Emergency contact name _______________________ Phone # __________________

Date of last eye exam ___________ Location ____________ Did they dilate your pupils? ___

Who referred you to our office? _________________

**Reason for today's visit:** ________________________________________________________

### MEDICAL INFORMATION

How is your general health? ______________________________

Do you have any problems with any of these systems? If yes, please check:

__ Gastrointestinal __ Nervous __Thyroid __ Mental/Psychological ___ Diabetes (type 1)

__ Blood/Lymph __ Urinary __Respiratory __ Skin/Dermatological

__ Headaches __Cholesterol __Eyes __ Ears/Nose/Throat ___ Diabetes (type 2)

__ Infectious Disease __ Auto immune __Heart __ High Blood Pressure

Other: please explain ________________________________________________

Allergies to medications? __Yes __ No Which? ____________ Reactions _____________

Current Medication(s): Check if none ( )

________________________________________________________________________

________________________________________________________________________

Have you had any operations? _____Yes _____No Kind? _______________

Name of family doctor _________________________ Phone# _______________

Date of last visit _________________________

### FAMILY HISTORY

Blood Pressure ______ relation _________

Diabetes ___________ relation _________

Glaucoma _________ relation _________

Macular Degeneration _____relation ______

Retinal Detachment ______ relation ______

Cataracts _____________ relation______

### PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ___ Yes ___ No What kind? ____________

Have you had any eye surgery? ___ Yes ___ No Type ______________

Have you had any eye injuries? ___ Yes ___ No Kind ______________

Do you have glaucoma? ___ Yes ___ No Cataracts? ___ Yes ___ No

Dry eyes? ___ Yes ___ No Macular Degeneration? ___ Yes ___ No

Blurred vision? ___ Yes ___ No Retinal Detachment? ___ Yes ___ No

Flashes/Floaters? ___ Yes ___ No Excessive Itching/burning/tearing? ___ Yes ___ No

Do you wear glasses? ___ Yes ___ No

Contact Lenses? ___ Yes ___ No, If yes which Type? ________ Brand? ______________

If yes, how many years have you worn contacts? _____________ Solutions used ________

Any additional information ____________________________________________________

**DAVID D'ALESSANDRO O.D.,P.A.**

50 E. MAIN ST, SUITE 4
LITTLE FALLS, NJ 07424
973-890-9044

64 SIP AVE
JERSEY CITY,NJ 07306
201-653-5626


Dear Patient,

Your insurance company and this office require you to read and sign below. Please note: a "routine" eye exam (a check up for glasses) is different from a "medical" eye exam (eye infections, treatments, disorders of the eye, etc...). Most insurances do not cover cosmetic contact lens fittings (please check with your carrier if they do). A contact lens fitting is separate from a "routine" exam.

**INSURED INFORMATION** Employer ____________________
Last Name ____________________ First Name ______________ MI ___ Date of birth _______
Address ______________________ City _________ State ___ Zip _______ Phone _________
Relationship to patient ___________ Married/Single/Divorced/Other________

**PATIENT INFORMATION** Check here if self ______
Last Name ___________________ First Name ______________ MI ___ Date of birth _______
Address______________________ City __________ State_____ Zip______Phone ________
Social Security # ______________ Married/Single/Divorced/Other _________ Gender __ M __ F

**VISION INSURANCE:** Name of Company ______________________________
ID # OR SOCIAL SECURITY# OF INSURED___________________ GROUP # ________

**HEALTH INSURANCE:** Name of Company ______________________________
ID # OR SOCIAL SECURITY # OF INSURED___________________ GROUP # ________

**MANAGED CARE STATEMENT OF PATIENT RESPONSIBILITY**

**Authorization to Furnish Information**
I authorize David D'Alessandro O.D., P.A. to furnish information to insurance carriers, referring physicians or legal guardians (for minors) concerning my eye conditions and treatments, or information needed for this or related claims, or associated with my insurance company's Quality Assurance program.

**Referral Responsibility**
If my insurance company expects me to obtain a referral or pre-authorization for this visit, I understand I must present this upon office check in and registration. If later my insurance company determines that I required a referral for payment of services and one was not provided, I will be responsible for the customary physician charges for this and related visits.

**"Not a Covered Service" Acknowledgement**
I acknowledge that I am responsible for determining my insurance company's coverage of services provided by Dr. David D'Alessandro. If my insurance company determines that this visit is "not a covered service" or down-codes a valid claim to pay a lower amount, I will be responsible for the customary physician charges for this and related visits.

**Assignment of Insurance Payment**
I also assign Dr. David D'Alessandro all payments for medical services rendered at his offices. I understand that I am responsible for any amount not covered by insurance. Any payments due from my insurance company but not paid is my responsibility and I will be responsible for this additional amount.

**Payment of Co-Pays**
If my insurance company expects a co-payment to Dr. David D'Alessandro for each visit, I will make this payment upon registration for any visit related to my healthcare. This includes post-operative visits to monitor surgical recovery, follow up visits for eye problems, or discussions of questions regarding my medical or vision condition.

**Payment after 60 Days**
If my insurance company delays payment of the claim for professional services beyond 60 days from initial submission of the claim, I will be responsible for payment of the customary charges for the physician visit. Any subsequent payment by the insurance company for this service will be appropriately refunded.

**Patient/Guardian Signature:** ______________________________________**Date**_________

**DAVID D'ALESSANDRO, O.D.,P.A.**

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# Notice of Privacy Practices
# Patient Acknowledgement

Patient Name: ______________________________________________

Date of Birth: ______________________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ___________________________________________

Date: _______________________________________

Relationship to patient (if signed by a personal representative of patient):

___________________________________________________