Dr. Laura C. Sperazza, OD
1760 Easton Avenue
Somerset, NJ 08873

Patient Information Date of Service__________

(Please circle) Mr./Mrs./Ms./Single/ Married

Patient Name___________________________________ DOB________Age____ Sex___

Last First MI

Address____

Town _______________________________State______ Zip Code_____________

Phone Number__________________________Work Number_______________________

Social Security Number_____________________Cell phone________________________

Insured Name________________________________**Insured DOB**________________

Email address____

Contact lens fit and evaluation policy

The fitting, evaluation and medical supervision of a corneal contact lens is **NOT** a covered benefit of traditional or HMO insurance plans. All fees are the responsibility of the patient and are due at the time of service. If you have any questions please ask the staff before the service is provided.

Insurance Information

Vision Insurance Carrier________________________________Policy #______________

Medical Insurance Carrier_______________________________Policy#______________

Signature on File

1. I authorize use of this form on all my insurance submissions.
2. I authorize release of information to all my insurance companies.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carries.
4. I authorize payment directly to my doctor.
5. I permit a copy of this authorization to be used in place of the original.
6. I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf for any services furnished. I authorize any holder of medical information about me to release to the health care financing administration and its agents' information needed to determine these benefits payable for related services.
7. Medicare does not pay for the refractive part of any eye exam. If refraction (part of the exam that determines your need for glasses) is necessary during the exam, Medicare will disallow it stating that it is not a covered service. Therefore, the patient will be responsible for the refraction charge.
8. I understand I am responsible for any amount of my bill not covered by my insurance.
9. A copy of Dr. Sperazza's Private Practices HIPPA notice is available on request.

Missed Appointment/ Non-cancellation Policy

Optim Eyes requires a notice of cancellation. We understand that unexpected incidences may cause you to cancel/reschedule your appointment but we require **at least 24-hour notice of cancellation**. There will be a $25 charge for missed or cancelled appointments with less than 24-hour notice of the scheduled visit.

Signature____Date_____________

Signature of Patient or Guardian if a minor

MEDICAL HISTORY QUESTIONNAIRE - *Adapted from the American Academy of Ophthalmology*

Name: ____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: ______________________________

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	____________
Loss of side vision, double vision	[ ]	[ ]	____________
Itching, burning, or discharge	[ ]	[ ]	____________
Redness	[ ]	[ ]	____________
Gritty feeling, dryness or tearing	[ ]	[ ]	____________
Glare/light sensitivity, or halos	[ ]	[ ]	____________
Eye pain or soreness	[ ]	[ ]	____________
Infection of eye lashes or lid, styes	[ ]	[ ]	____________
Ears, nose, mouth, throat	[ ]	[ ]	____________
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	____________
Respiratory (lungs/breathing)	[ ]	[ ]	____________
Gastrointestinal (stomach/intestines)	[ ]	[ ]	____________
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	____________
Musculoskeletal (muscles/joints)	[ ]	[ ]	____________
Integument (skin/breast)	[ ]	[ ]	____________
Neurological	[ ]	[ ]	____________
Psychiatric	[ ]	[ ]	____________
Endocrine (hormones, glands)	[ ]	[ ]	____________
Hematologic/Immunologic (blood)	[ ]	[ ]	____________
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	____________

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	

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Allergies to eye drops	[ ]	[ ]	List drops you are allergic to:
History of cataract, glaucoma	[ ]	[ ]	____________
History of cross/lazy eye	[ ]	[ ]	____________
Eye injury or other disease	[ ]	[ ]	____________
Eye surgery	[ ]	[ ]	____________

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: ____________________________

List all major illnesses: Diabetes ________ Hypertension ________
Other: ____________________________

List any major surgical procedures: ____________________________

Do you have any medication allergies? [ ] NO [ ] YES Penicillin Sulfa
List other medication allergies: ____________________________

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	____________
Cataract	[ ]	[ ]	____________
Glaucoma	[ ]	[ ]	____________
Macular degeneration	[ ]	[ ]	____________
Retinal detachment	[ ]	[ ]	____________
MEDICAL			
Diabetes	[ ]	[ ]	____________
Arthritis, lupus, etc.	[ ]	[ ]	____________
Other (list)	[ ]	[ ]	____________

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	____________
Did you have problems with contacts?	[ ]	[ ]	____________

Vision causes problems with:
❑ Driving ❑ Night vision ❑ Reading ❑ Sports/Outdoor activities

GENERAL

Do you drink alcohol? [ ] [ ] How much per day? ________________
Do you smoke? [ ] [ ]

Patient's signature: ______________________ Date: ______________

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature: ______________________ Date: ______________