Registration : Cornea Consultants Of Albany

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Cornea Consultants Of Albany , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Cornea Consultants Of Albany
9 Vista Blvd Suite 100 Phone: 518-475-1515
Slingerlands, NY 12159 Email:

Please attach all pertinent insurance ID cards for photocopying.

Cornea Consultants of Albany, PLLC

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____
Date of Birth: _____
Date of Visit: _____

Date of Last Eye Exam: _____

List Any Eye Medications/Drops You Currently Use: _____

List Any Other Medications You Currently Take: _____

List Any Allergies to **Medications**: _____

List All Major Illnesses (Glaucoma, Diabetes, High Blood Pressure, etc.) or Injuries (Concussion, etc.): _____

List Any Eye Surgeries You Have Had (Cataract, LASIK, etc.) and Approximate Date: _____

List Any Other Surgeries You Have Had (Tonsillectomy, Appendectomy, etc.): _____

Do you ***currently*** have any problems in the following areas? If **YES**, please explain.	YES	NO	DETAILS
EYE HISTORY			
Loss of vision			
Blurred Vision			
Fluctuating vision			
Double Vision			
Distorted Vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Dryness			
Sandy or gritty feeling			
Redness			
Itching			
Burning			
Excess tearing or watering			
Eye pain or soreness			
Mucous Discharge			
Tired Eyes			

MEDICAL HISTORY QUESTIONNAIRE - CONTINUED

GENERAL HISTORY	YES	NO	DETAILS
General/Constitutional (fever, weight loss, etc)			
Ears, Nose, Throat (sinus, ear infection, etc)			
Cardiovascular (high blood pressure, heart, etc)			
Respiratory (congestion, wheezing, etc)			
Gastrointestinal (stomach upset, diarrhea, etc)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, etc)			
Muscles, Bones, Joints (joint pain, stiffness, etc)			
Skin (acne, warts, growths, rash, etc)			
Neurological (numbness, headache, etc)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc)			
Blood/Lymph (cholesterolemia, anemia, etc)			
Allergic/Immunologic (hay fever, etc)			

FAMILY HISTORY			M=Mother F=Father S=Sibling GP=Grandparent
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Age Related Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Other			

SOCIAL HISTORY

Current Occupation: _____

Education: _____

Marital Status: _____

Living Arrangements (Nursing Home, Assisted Living, Rehabilitation, etc): _____

Alcohol Consumption: ☐None ☐Occasionally ☐1/Day ☐2-3/Day ☐4+/Day

Smoking Habits: ☐None ☐Occasionally ☐1/2 Pack/Day ☐1 Pack/Day ☐1+Pack/Day

Do You Drive? ☐YES ☐NO

Have You Ever Worn Contact Lenses? ☐YES ☐NO

Do You Currently Wear Contact Lenses? ☐YES ☐NO If Yes, How Long? _____

Do You Currently Wear Glasses? ☐YES ☐NO If Yes, How Long? _____

Patient's Signature: _____ *Date:* _____

Physician's Signature: _____ *Date:* _____

SPEED™ QUESTIONNAIRE

Name: _____ **Date:** ___/___/___ **Sex:** M F (Circle) **DOB:** ___/___/___

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** _____

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For office use only
Total SPEED score (Frequency + Severity) = ___/28

Refraction Service and Fee Information

A refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary to write a prescription for glasses.

Most medical insurance plans, including Medicare, DO NOT COVER ROUTINE REFRACTIONS OR ROUTINE EYE EXAMINATIONS (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a refraction is **$35.00** and this fee will be billed to you in addition to your co pay, coinsurance, and/or deductible. Should your plan pay us for this refraction, you will not receive a bill. If you have any questions, please do not hesitate to call us at 518-475-1515. Ask for a technician.

While we stand behind our prescriptions, we cannot take responsibility for the manufacture of the actual glasses. In particular, placement of the prescription in progressive bifocals can affect the comfort of the wear. If you're having problems with your glasses bring them back to the optician that made them. If you feel there is a problem with the actual prescription, then you need to return here. If a change in the prescription is actually needed, there will be no charge for the visit. Otherwise, a fee **($35.00)** for a "glasses check" will be charged.

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you **make arrangements not to drive yourself.**

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Missed Appointments

It is important that you keep your scheduled **follow-up appointments**. Failure to do so may result in a **$40.00** missed appointment fee for not calling our office at least 24 hours in advance to reschedule.

Patient Acknowledgement

I have read the above information. I accept full financial responsibility for the cost of these services.

_____ _____

Patient Signature (Parent of Minor) Date