DR. JOSEPH K. YOUNG
VILLAGE EYE CARE
OD

Thank you for working with us!

Name:_____ Date: _____

Check off your answer

Have you tested positive for Covid-19 in the last 14 days?

YES	NO

Have you been in close contact with another person who has been diagnosed or has tested positive for COVID-19 in the last 14 days?

YES	NO

Have you experienced coughing, fever or shortness of breath in the last 10 days?

YES	NO

INTENTIONALLY BLANK

INTRODUCING OPTOMAP

Name:_____ Date: _____

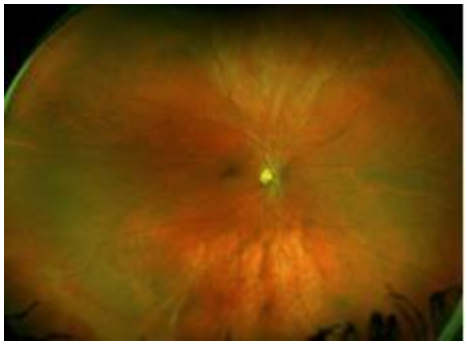
We are pleased to offer Optomap Ultra-Wide Digital Retinal Imaging to our patients. It is important for Dr. Young to review your retina health. Optomap Ultra-Wide Digital Retinal Imaging can find issues ranging from retinal detachments/tears to hypertension or diabetes.

The Optomap is eye care technology is used to see the back of the eye. It is much like dilation but avoids the after-effects such as light sensitivity and blurry vision which lasts for a few hours. Optomap is quick and easy allowing you to complete your comprehensive exam significantly faster.

Insurance at this time allows the procedure to be done in a routine examination with a $39 copay.

Do you want the Optomap?

☐ Yes. I understand that there is an additional $39 fee.
☐ I want to be dilated. I do not want the Optomap.
☐ I do not want either. Refusal for retinal imaging/dilation must be signed.



Dr. Joseph K. Young @ Village Eye Care
(203) 426-5586
2020vec@gmail.com
http://www.DrYoung2020.com

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Medical History Questionnaire

Please fill this out to the best of your ability, circling or writing, even if you are an established patient. Quite often symptoms change yearly. ***Even circling "No" helps Dr. Young assess your vision needs better***.

If you are a new patient, how did you hear of us? _____

Name: _____ Today's Date: _____

Address: _____ Day Phone #: _____

City, St. Zip: _____ Cell Phone #: _____

Email: _____ Preferred Language: English or Spanish

Birth date: _____ Last 4 SS#: _____

Medical Dr.: _____ Last Medical Exam: _____

Eye Dr. (if new): _____ Last Vision Exam: _____

Vision Ins.: _____ Medical Ins.: _____

Height: _____ Weight: _____ Ethnicity: Hispanic/Latino or Native Hawaiian/other Pacific Island or Neither

Race: American Indian / Alaska Native / Asian / Black / African American / Hispanic / Native Hawaiian / other Pacific Island / White

*Please circle your answers below. Don't forget to circle "**No**" if applicable.*

Reason for Visit:
Normal Comprehensive Eye Exam OR **Concern**:_____

Eye History:
Do you wear glasses? Yes or No
Do you wear contacts? Yes or No If yes, what brand & prescription? _____

Have you been diagnosed with/treated for:

Strabismus Yes or No
Vision Therapy Yes or No
Optic Nerve Disease Yes or No
Keratoconus Yes or No
Macular Degeneration Yes or No
Glaucoma Yes or No
Diabetic Retinopathy Yes or No
Retinal Detachment Yes or No
Retinal Disease Yes or No

Have you ever had eye surgery?

☐ Cataract
☐ Left Eye ☐ Right Eye ☐ Both
☐ Laser Vision Correction
☐ Other:

Has anyone in your family had any of the following?

Macular Degeneration Yes or No If yes, who? _____
Glaucoma Yes or No If yes, who? _____

Other_____

Review of Systems:

Have you ever had problems in the following areas? *Please circle all that apply. Don't forget to circle "**No**" if applicable.*

1) Ocular problems such as:
   Eye Pain, Blurred Vision, Double Vision, Flashes/Floaters, Dryness, Night Vision
2) Allergies? **YES** **NO**
3) Vascular/Cardiovascular problems? **YES** **NO**
   High Blood Pressure □ Other □ _____
4) Constitutional problems (i.e. High Fever or Severe Weight Gain/Loss)? **YES** **NO**
5) Endocrine problems (i.e. Thyroid or Diabetes)? **YES** **NO**
6) Gastrointestinal problems (i.e. Acid Reflux)? **YES** **NO**
7) Genitourinary problems (i.e. Kidney Stones or Bladder Infections)? **YES** **NO**
8) Ear, Nose or Throat problems? **YES** **NO**
9) Lymphatic/Hematologic problems (i.e. Anemia)? **YES** **NO**
10) Immunologic problems? **YES** **NO**
11) Integumentary/Skin problems (i.e. Rosacea or Eczema)? **YES** **NO**
12) Musculoskeletal (i.e. Arthritis or Bone Degeneration)? **YES** **NO**
13) Neurological problems (i.e. Migraines or Seizures)? **YES** **NO**
14) Psychiatric Matters? **YES** **NO**
15) Respiratory problems (i.e. Asthma or Emphysema)? **YES** **NO**

Any Additional Information:

_____

_____

Medical History: Please list **ALL** medications you are taking including eye drops, over-the counter and medications that you may not think is relevant. Many medications have ocular side effects.

_____

_____

_____

Medication Allergies: **Yes or No** If yes, name of medication(s): _____

Pregnant or Nursing: **Yes or No**

Social History:
Do you drink alcohol? **Yes or No** Do you smoke? **Yes or No**

I have answered these questions to the best of my knowledge. *All unanswered questions are assumed as "No" or "None".*
I have read and understand the HIPAA statement that has been posted in the office of Village Eye Care.

Patient/Guardian Signature: _____

Patient Financial/HIPAA Agreement

Payment is expected at the time services are rendered, including non-covered portions of insurance. Some insurance companies (including Medicare) do not cover services such as Optomap Retinal Imaging or refractions.

Please note: most policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. While we do call or go online to insurance companies to receive benefit information, we cannot guarantee the accuracy of the information provided. Please understand that financial responsibility for your account is ultimately yours, not that of your insurance company.We are pleased to be able to provide the service of filing your insurance and will forward a bill of any unpaid benefits should there be any. Unpaid accounts are subject to collection fees and will be transferred to IC System Inc. There will be a service charge of $25.00 on all returned checks. Collection fees will be assessed at 25% of the outstanding balance if a collection agency is used to collect your debt. The collection fee will be in addition to your outstanding balance.

Although some vision insurance plans provide full or partial coverage for contact lens fittings/evaluations, many insurance companies do not consider this service to be medically necessary. In the event that your contact lens fitting/evaluation is not covered, you will be notified of and financially responsible for the full amount due. The cost of contact lens fittings/evaluations are dependent upon your prescription as calculated by the doctor, the brand of lenses required for your prescription and the complexity of the fitting.

I have read and understand the HIPAA privacy form posted in the reception area.

I hereby authorize payment of benefits for services described as per assignment designation and assume responsibility for prompt payment of charges in the event of any outstanding balance for today's service as well as any other future services. I also assume responsibility for any check charges or collection fees that may occur should I default in payment. Additionally, I authorize the release of any information necessary to process claims should I utilize vision or medical insurance forservices rendered.

Patient/Guardian Signature:_____ **Date:** _____