IF FILLING THIS FORM OUT AT THE OFFICE, FOR YOUR SAFETY, PLEASE KEEP YOUR PEN!

Check off your answer.

Have you been in close contact with another person who has been diagnosed with or under investigation for COVID-19?

YES NO

Have you experienced coughing, fever or shortness of breath in the last 14 days?

YES NO

In the last two weeks, have you been outside of the Northeast?
The Northeast=CT, NY, NJ, MA, NH, ME, VT, PA & RI

YES NO

Intentionally Blank

DR. JOSEPH K. YOUNG VILLAGE EYE CARE O.D.

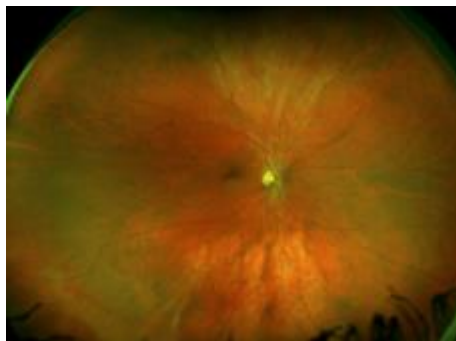
Name: ________________________________ Date: ____________________

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 used to see the back of the eye much like dilation but avoiding dilation after-effects such as light sensitivity and blurry vision lasting for a few hours. Optomap is quick and easy taking about 15 minutes allowing you to complete your comprehensive exam significantly faster.

Some insurance companies may cover it, yet some may not. If your insurance company does not cover it, we are offering Optomap Imaging to our patients for $39. It is normally $125. Feel free to ask us.

☐ Yes. I understand that there is an additional $39 fee.
☐ No. I want to be dilated.
☐ 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

Intentionally Blank

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 PLEASE EXPLAIN YOUR YES ANSWERS!*

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 Eyes
☐ 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, Flashers/Floaters ,Dryness, Night Vision **YES NO**

2) Allergy **YES NO**

3) Vascular/Cardiovascular problems? High Blood Pressure ☐ Other ☐ _______________ **YES NO**

4) Constitutional problems (i.e. High Fever or Severe Weight Gain/Loss)? **YES NO**

5) Endocrine problems (i.e. Thyroid)? 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 **YES NO**

15) Respiratory problems (i.e. Asthma or Emphysema)? **YES NO**

Explanation:

____

____

Medical History: Please list **ALL** medications you are taking (including eye drops and over-the counter):

____

____

____

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. 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 for services rendered.

Patient/Guardian Signature: ____________________________________ **Date:** ______________