

**WELCOME TO OUR OFFICE**

Date: \_\_\_\_\_  
 Last: \_\_\_\_\_  
 First: \_\_\_\_\_  
 Street \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work number: \_\_\_\_\_  
 Cell Number: \_\_\_\_\_  
 Emergency contact name: \_\_\_\_\_  
 Emergency contact number: \_\_\_\_\_  
 Patient Date Of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: **M F**  
 Employer/School: \_\_\_\_\_  
 Occupation/Grade: \_\_\_\_\_  
 Spouse/Parents Name: \_\_\_\_\_  
 Spouse/Parents Work: \_\_\_\_\_  
 E-Mail address: \_\_\_\_\_  
 Any problems with your present contact lenses or glasses?  
 Please explain: \_\_\_\_\_

**INSURANCE INFORMATION**

**Vision insurance:** \_\_\_\_\_  
 Subscriber name: \_\_\_\_\_  
 Subscriber ID number: \_\_\_\_\_  
 IF VSP last four digits of subscriber SSN: \_\_\_\_\_  
 IF Eyemed subscriber SSN: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_  
**Medical Insurance:** \_\_\_\_\_  
 Subscriber name: \_\_\_\_\_  
 Subscriber ID number: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_  
**Secondary Medical Insurance** \_\_\_\_\_  
 Subscriber name: \_\_\_\_\_  
 Subscriber ID number: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_

**FAMILY MEDICAL/EYE HISTORY (CHECK ALL THAT APPLY)**

|   | Relationship |
|---|--------------|
| <input type="checkbox"/> Blindness                | _____        |
| <input type="checkbox"/> Cataracts                | _____        |
| <input type="checkbox"/> Corneal Problems         | _____        |
| <input type="checkbox"/> Glaucoma                 | _____        |
| <input type="checkbox"/> Macular Degeneration     | _____        |
| <input type="checkbox"/> Retinal Problems         | _____        |
| <input type="checkbox"/> Lazy Eye                 | _____        |
| <input type="checkbox"/> Diabetes                 | _____        |
| <input type="checkbox"/> High Blood Pressure      | _____        |
| <input type="checkbox"/> Heart Disease            | _____        |
| <input type="checkbox"/> Other Eye/Health Problem | _____        |

**PATIENT MEDICAL HISTORY**

Name of Family Physician: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Date of last Physical Check-up: \_\_\_\_\_

**MEDICAL HISTORY & CURRENT MEDS (Rx or over the counter)**

(List name of medications including eye drops, vitamins & birth control pills)

Allergies to medications  YES  NO

List: \_\_\_\_\_

Have you been diagnosed or treated for any of the following?

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney      |
| <input type="checkbox"/> Lyme Disease  | <input type="checkbox"/> Nerves              | <input type="checkbox"/> Thyroid     |
| <input type="checkbox"/> Other: _____  |  |                                      |

**VERY IMPORTANT**

Who may we thank for referring you to our office? \_\_\_\_\_  
 If not referred, how did you choose our office for your visual needs?  
 Internet \_\_\_\_\_ What website? \_\_\_\_\_  
 Relative  Friend  Doctor  
 Insurance  Drive By  
 Other \_\_\_\_\_

**PATIENT EYE HISTORY**

Date of last exam: \_\_\_\_\_  
 By Whom: \_\_\_\_\_  
 Do you currently wear contact lenses?  YES  NO  
 What Kind? \_\_\_\_\_  
 If not, are you interested?  YES  NO  
**Do You...**  
 ...Have more than 1 pair of glasses?  YES  NO  
 ...Work at a computer for long periods of time?  YES  NO  
 ...Want information on Laser Vision Correction?  YES  NO  
 ...Have family in need of eye care now?  YES  NO

**Have you ever been diagnosed or treat for the following?**

- |   |   |
|---|---|
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Corneal Abrasion           |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Eye Infection              |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Iritis/Uveitis             |
| <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> Other eye disorders: _____ |
| <input type="checkbox"/> Eye injury           | <input type="checkbox"/> Lazy Eye                   |

**Do you or have you experienced?**

- |   |   |
|---|---|
| <input type="checkbox"/> Blurry Vision        | <input type="checkbox"/> Floaters/Black Spots             |
| <input type="checkbox"/> Reading Problems     | <input type="checkbox"/> Headaches                        |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Dryness                          |
| <input type="checkbox"/> Flashes of Lights    | <input type="checkbox"/> Light Sensitivity                |
| <input type="checkbox"/> Crossed Eye/Eye Turn | <input type="checkbox"/> Trouble Seeing at Night or Glare |
| <input type="checkbox"/> Redness              | <input type="checkbox"/> Tearing                          |
| <input type="checkbox"/> Eye Pain             | <input type="checkbox"/> Burning                          |
| <input type="checkbox"/> Itchiness            | <input type="checkbox"/> Grittiness                       |

Doctors Signature: \_\_\_\_\_

# Vision North

Dr. Paul M. Cangiano

**Contact Lens Fees:** Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes. Please ask us for a quote on these additional fees.

**Assignment of Benefits:** I request that payment of authorized Medicare or other assigned insurance made directly to Vision North/Dr. Paul M. Cangiano, O.D. for any services rendered. I authorize this holder of my medical information to be released to CMS, agents and information to determine the benefits payable for related services.

If patient is under 18 years of age, guarantor (person responsible for payment it:

Name \_\_\_\_\_ Address \_\_\_\_\_

I understand that I am responsible for any non-covered services

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

(Parent/guardian if under 18)

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices, HIPAA.

Signature or Patient \_\_\_\_\_ Date \_\_\_\_\_

(Parent/guardian if under 18)

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