SPRINGFIELD EYECARE  OPTICIANS PROFESSIONALS

PATIENT INFORMATION

(Please Print)

PERSONAL INFORMATION

Today's Date _____

Last Name _____ First Name _____ Title: (circle one) Mr Mrs Ms Other _____

Street Address _____

City _____ State _____ Zip _____

Home Phone# (____) _____ Work Phone# (____) _____ Cell Phone# (____) _____

Birth Date ____/____/____ Age _____ Sex: ☐ Male ☐ Female Social Security _____-_____-_____

Occupation _____ Employer _____ Email _____

Person to contact in case of emergency _____ Contact Phone # _____

Referred By: ☐ Yellow Pages ☐ Newspaper ☐ Doctor ☐ Other _____

Family Physician _____ Last General Exam _____

Previous Eye Doctor _____ Last Eye Exam _____

Do you presently wear glasses? _____ Do you presently wear contact lenses? _____

Please check all that apply:

General Health: ☐ Hypertension ☐ Liver Disease ☐ Thyroid Disease ☐ Lung Disease
☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Other _____

Medications: _____

Allergies: _____

Ocular History: ☐ Glaucoma ☐ Cataracts ☐ Eye turn / Lazy eye
☐ Eye Surgery ☐ Eye Trauma ☐ Other _____

Family History: ☐ Glaucoma ☐ Eye turn / Lazy eye ☐ Liver Disease ☐ Kidney Disease
☐ Eye Surgery ☐ Hypertension ☐ Heart Disease ☐ Lung Disease
☐ Cataracts ☐ Diabetes ☐ Thyroid Disease ☐ Other _____

Eye Complaints: ☐ Itching ☐ Burning ☐ Tearing
☐ Floating Spots ☐ Flashes of Light ☐ Double Vision
☐ Eye Pain ☐ Loss of Vision ☐ Blur at Distance
☐ Blurry Vision at Near ☐ Other _____

INSURANCE INFORMATION

Primary Vision Carrier: ☐ **Aetna** ☐ **Personal Choice/PA BCBS** ☐ **Vision Service Plan (VSP)**
☐ **Davis Vision** ☐ **Superior Vision** ☐ **Other** _____
☐ **Keystone** ☐ **Union Plans**
☐ **Medicare** ☐ **Vision Benefits of America (VBA)**

Insured's Last Name _____ **Insured's First Name** _____

Insured's ID# _____ **Group ID#** _____

Relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Insured's Street Address (If different) _____

Insured's City _____ **State** _____ **Zip** _____

(over)

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Thomas Piorkowski and/or Springfield Opticians all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hearby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGN HERE _____ **Date** _____

HIPAA PRIVACY

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the location).

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

_____ _____

Patients Signature or Patient's Legal Representative **Date**

ATTENTION ALL CONTACT LENS PATIENTS ONLY

of Springfield Opticians

Please be advised that there is a seperate fee for your contact lens evaluation. This fee applies to BOTH new and previous contact lens wearers. This fee is due at time of service. Most insurance plans do NOT cover this fee. In compliance with the Pennsylvania State Law your prescription will expire after 1 year. You will need to be re-evaluated before purchasing more contacts. Contacts are a medical device that you place internally in your eye. These policies are in place for the safety and health of your eyes.
Thank you for your cooperation.

X_____ **Date** _____