Envisions Eyecare Centers, Inc

Elegance N Eyewear Boutique

Dr. John S. Corvese and Associates

EAST PROVIDENCE	PROVIDENCE	CRANSTON	WEST WARWICK	NORTH PROVIDENCE
1970 Pawtucket Avenue	319 Pocasset Avenue	868 Reservoir Avenue	328 Cowesett Avenue	1543 Smith Street
East Providence, RI 02914	Providence, RI 02909	Cranston, RI 02910	West Warwick, RI 02893	North Providence, RI 02911
(401) 438-1166 (Tel.)	(401) 942-1444 (Tel.)	(401) 942-9933 (Tel.)	(401) 821-4300 (Tel.)	(401) 353-2010 (Tel.)
(401) 603-4169 (Fax)	(401) 603-4170 (Fax)	(401) 603-4171 (Fax)	(401) 603-4568 (Fax)	(401) 603-4570 (Fax)

Courtesy Office Visit Reminder:

Please Bring in Your

- Completed or Updated Medical History Form (forms are required to be updated every two years)
- Current Glasses
- Current Contact Lenses Prescription or box
- Health Insurance Card
- Photo ID

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ Today's Date: ______________

Address: ______________________ Home Phone: ______________

City: __________ State: ______ Zip: ______ Work Phone: ______________

Birth Date: __________ Social Security #: __________ Cell Phone: ______________

Sex: Last Eye Exam: __________ Email Address: ______________

(Email is recommended for reminders such as; routine exam, glasses and contact lens pickup)

If patient is a minor, please indicate parent/guardian name(s): ______________________

Name of Primary Doctor: ______________________ Dr.'s Phone: ______________

Name of Secondary Doctor: ______________________ Dr.'s Phone: ______________

REASON FOR TODAY'S VISIT: ❐routine visit ❐eye problem ❐glasses ❐contacts ❐CRT ❐Lasik Surgery
Referred by ______________

Are you pregnant and/or nursing: ❐ no ❐ yes

Do you wear glasses: ❐ no ❐ yes If yes, how old is your present prescription? ______________

Do you wear contact lenses? ❐ no ❐ yes If yes, how old is your present prescription? ______________

Type of contact lenses: ❐ Rigid ❐ Soft ❐ Extended Wear ❐ Other Are they comfortable? ❐ yes ❐ no

MEDICAL HISTORY

Do you have any allergies to medications? ❐ no ❐ yes If yes, explain: ______________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ______________________

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❐	❐	❐	______________
Cataract	❐	❐	❐	______________
Crossed Eyes	❐	❐	❐	______________
Diabetes	❐	❐	❐	______________
Glaucoma	❐	❐	❐	______________
Macular Degeneration	❐	❐	❐	______________
Retinal Detachment / Disease	❐	❐	❐	______________
Arthritis	❐	❐	❐	______________
Cancer	❐	❐	❐	______________
Heart Disease	❐	❐	❐	______________
High Blood Pressure	❐	❐	❐	______________
Kidney Disease	❐	❐	❐	______________
Lupus	❐	❐	❐	______________
Thyroid Disease	❐	❐	❐	______________

***** PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO *****

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer. ❒ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

Do you use tobacco products? ❒ no ❒ yes If yes, type / amount / how long: ____________________

Do you drink alcohol? ❒ no ❒ yes If yes, type / amount / how long: ____________________

Do you use illegal drugs? ❒ no ❒ yes If yes, type / amount / how long: ____________________

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems
Do you currently, or have you ever had any problems in the following areas:

SYSTEM	*NO*	*YES*	*?*
CONSTITUTIONAL			
Fever, Weight Loss/Gain.	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision / Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing / Watering	❒	❒	❒
Glare / Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid . .	❒	❒	❒
Sties or Chalazion.	❒	❒	❒
Flashes / Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thryoid / Other Glands..............	❒	❒	❒

	NO	*YES*	*?*
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat / Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals / Kidney / Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle / Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems.	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

ENVISIONS EYECARE CENTERS POLICIES

By signing this form, I knowingly agree to and understand the following terms:

1. All charges for services are due at the time they were rendered. New patients who do not have insurance card/information will be responsible for services that day.

2. If your insurance requires a referral, it is YOUR responsibility to obtain one PRIOR to services being rendered. If one is not obtained, you will be responsible for any charges incurred for your visit.

3. All copays are due at the time of visit. All unpaid copays will be billed out and will include a $10 billing fee unless specific prior arrangements have been made and approved.

4. All purchases require a 50% deposit and must be paid in full at pickup. We will hold all eyeglass/contact lens orders for 90 days. After that point CONTACT LENSES will be returned and will incur a 15% restocking fee. EYEGLASSES will be dissembled and the DEPOSIT will not be refunded.

5. Our frames are priced to reflect a 20% discount off suggested retail prices. This discount may not be combined with any discount that may be offered by your insurance.

6. Any portion of my bill not paid by my insurance is my full responsibility. Balances left unpaid after 30 days will be subject to an 18% interest rate fee as well as a $10 monthly billing fee. Delinquent accounts will be sent to a collections attorney, and I will be responsible for my balance as well as any applicable legal fees.

7. Any new or existing patients that do not cancel their appointment within 24 hours in advance will be charge a **NOSHOW/CANCELATION FEE of $55.00.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read, received, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient/Guardian (Signature)____ **Date** ____________________

Print Full Name of Patient ____