CT EYE PHYSICIANS & SURGEONS RICHARD J. MANGANIELLO, M.D.

APPOINTMENT DATE: _____

LAST NAME: _____ FIRST NAME: _____MIDDLE INITIAL: _____

STREET ADDRESS: _____

TOWN: _____ STATE: _____ ZIP CODE: _____

CELL: _____ LANDLINE: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

☐ MALE ☐ FEMALE ☐ OTHER SOCIAL SECURITY #: _____ - _____ - _____

DATE OF BIRTH: _____

☐MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ PARTNERED

PRIMARY CARE PROVIDER: _____ REFERRING PROVIDER: _____

RETAIL PHARMACY: _____ MAIL ORDER: _____
EMERGENCY CONTACT NAME/PHONE: _____RELATIONSHIP: _____

LANGUAGE: ☐ ENGLISH ☐ OTHER: _____

RACE: ☐ NATIVE AMERICAN ☐ BLACK OR AFRICAN AMER. ☐ HAWAIIAN OR PACIFIC ISLAND
☐ ASIAN ☐ WHITE ☐ UNKNOWN

INSURANCE INFORMATION

PLEASE NOTE THAT THIS PROVIDER IS NOT CONTRACTED WITH VISION INSURANCE, DOES NOT BILL ROUTINE EXAMS THROUGH MEDICAL OR VISION CARRIERS AND IS NO LONGER CONTRACTED WITH MEDICAID.

1) PRIMARY INSURANCE: _____ ID# _____GROUP: _____

SUBSCRIBER'S NAME _____SUBSCRIBER'S DATE OF BIRTH _____ / ____ / ____

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER:

2:) SECONDARY INSURANCE: _____ID: _____GROUP: _____

SUBSCRIBER'S NAME _____SUBSCRIBER'S DATE OF BIRTH _____ / ____ / ____

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _____

TURN THIS PAGE OVER AND ANSWER REMAINING QUESTIONS

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

____ DECREASED DISTANCE VISION ____ FLOATERS ____ CHANGE IN FLOATERS ____DIMMING OF VISION

____ DECREASED NEAR VISION ____ FLASHES OF LIGHT ___ WORSENING NIGHT VISION

____ ITCHING, REDNESS, OR TEARING____ DOUBLE VISION **____ OTHER** (please explain**): _____**

SHOULD YOU HAVE ANY QUESTIONS ABOUT REIMBURSEMENT ON MEDICAL EXAMS OR MEDICATION COSTS, PLEASE CALL YOUR INSURANCE CARRIER. THERE ARE HUNDREDS OF PLAN TYPES UNDER INSURANCE CARRIERS WE WORK WITH AND MEDICAL OFFICES ARE NOT THE BEST RESOURCES ON REIMBURSEMENT QUESTIONS.

PLEASE USE THE PHONE NUMBER ON THE BACK OF YOUR MEDICAL INSURANCE CARD OR PRESCRIPTION RX CARD FOR ALL OST QUESTIONS.

IF YOU NEED ASSISTANCE WITH THIS, PLEASE LET OUR FRONT OFFICE STAFF KNOW.

FINANCIAL AUTHORIZATION: I certify that insurance information I have provided is accurate. I am responsible for all co-payments, deductibles, refraction fees and balances not covered by my medical insurance. I have read this document regarding insurance carriers and Routine Exams that this provider does not offer. **I agree to pay any co-payments, refraction fees and deductibles and any other fees NOT covered by my insurance carrier.** I agree to pay a $35.00 fee for each returned or NSF check.

SIGNATURE: _____ NAME: (PRINT) _____

NAME: _____ DOB: _____

MEDICATION ALLERGIES OR REACTIONS TO MEDICATIONS

_____

DO YOU HAVE DIABETES?

___ **TYPE ONE** ___**TYPE TWO**

DO YOU KNOW YOUR LAST A1c LEVEL? _____

WHAT EYE CONCERNS OR NEEDS WOULD YOU LIKE THE DOCTOR TO ADDRESS TODAY?

BRIEFLY ANSWER THE FOLLOWING:

PAST AND CURRENT EYE CONDITIONS_____

PAST EYE
SURGERIES_____

PAST AND CURRENT MEDICAL
CONDITIONS_____

DO YOU CURRENTLY OR HAVE IN THE PAST SMOKED OR VAPED?

DO YOU CURRENTLY OR HAVE IN THE PAST USE DRUGS RECREATIONALLY?

DO YOU CURRENTLY DRINK? ___SOCIALLY __REGULARLY ____ FREQUENTLY

CURRENT MEDICATIONS (ALL medications, not just eye-related): □ **check here if you are attaching a list**

MEDICATION NAME	STRENGTH/DOSAGE	STRENGTH/DOSAGE

NON-COVERED BY MEDICAL INSURANCE

REFRACTION is the process of determining refractive error; and is done for diagnostic purposes as well as for establishing any need for corrective lenses (eyeglasses). This is an essential part of an eye examination; and is done during a complete medical eye exam as a standard of responsible care. Unfortunately, Medicare and some commercial insurance carriers choose not to cover this service, even while recognizing the need for it.

The patient fee for refraction is $40.00 if your insurance plan does not cover this service. This fee is *in addition to* any co-pay, co-insurance, or deductible required by your insurance. In order to keep billing costs down, we will ask for refraction payments at the time of your appointment if it is not a covered service on your insurance plan.

CONTACT LENS

Current Contact Lens Wearers

The fee for a complete, updated contact lens prescription is $50.00. This service is provided for those patients who are happy with their current brand of contact lenses and wish to have the fit, prescription strength, and suitability checked so that refill lenses can be ordered locally or online. You will need to wear your current contact lenses in for the exam and bring the boxes that have the measurements printed on them. This fee is not covered by medical insurance plans and will be collected at the time of service.

New Contact Lens Wearers

The fee for a new contact lens package is $100.00. This service includes the contact lens fitting, education on the best contact lens brand for your eyes, instruction on inserting and removing your contact lens and free contact lenses to try. This fee is not covered by medical insurance plans and will be collected at the time of service.

I understand that these fees are to be paid at the time of service and are in addition to co-pays, co-insurances and deductibles.

If you have vision insurance that will cover any of these fees, please let us know and we will give you an itemized receipt to submit to your carrier after you have paid them here.

Patient Signature: _____ DATE: _____

Patient Name (printed): _____

If signed by someone other than the patient, please print name and relationship to patient:

_____