Welcome to the Francis Eye & Laser Center

Name: _____Todays Date: _____

Street Address: _____Apt/# Floor: _____

City: _____State:_____Zip Code: _____

Home Phone: _____Cell Phone: _____ DOB: _____

Primary Care Doctor: _____Pharmacy:_____

Gender: □F □M Age:_____ Language:_____ Employer:_____

Welcome to the Francis Eye & Laser Center! We are pleased that you have chosen us as your primary eye care provider. Please fill out this form to the best of your ability. Our dedicated team is here to assist you.

Ocular History

Have you ever been diagnosed with any of the following conditions?

□ Cataract
□ Diabetic Retinopathy
□ Floaters and/or Flashes of Light
□ Macular Degeneration
□ Dry Eye
□ Iritis or Uveitis
□ Glaucoma
□ Eye Infection/ Allergy/Inflammation
□ Retina defects

Do you have any of the following eye concerns? ☐ Dryness ☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge

Please list any additional concerns: _____

Do you have any of the following vision concerns?

□ Blurred Vision □ Far □ Near
□ Severe Sensitivity to Light
□ Night Glare
□ Eyestrain
□ Headache
□ Double Vision
□Eye Pain
□ Poor Night Vision
□ Total Loss of Vision

Please list any additional concerns: _____

GLASSES HISTORY

Are you planning to get new glasses today? □Yes □No
Do you currently wear glasses? □Yes □No
Do you wear sunglasses? □Yes □No
Are your sunglasses your most recent prescription? □Yes □No

CONTACT LENS HISTORY

Are you interested in trying contact lenses today? □Yes □No
Do you currently wear contact lenses? □Yes □No
If not currently wearing contact lenses, have you tried before? □Yes □No Why did you stop? _____

Medical History

Insurance name and ID#: _____Specialist: _____
Are you allergic to any medications: □Yes □No If yes, which ones: _____
_____
List any major surgeries: _____
Do you smoke: □ Yes □ No Do you drink alcohol? □ Yes □ No Do you drive? □ Yes □ No
Are you pregnant or nursing? □Yes □No
If you have ever been exposed to HIV, Hepatitis, Tuberculosis, Chlamydia, or Gonorrhea please discuss with your doctor.

Current Medications including eye drops: □ See Medication Listed

1. _____for _____ 6. _____ for _____
2. _____for _____ 7. _____ for _____
3. _____for _____ 8. _____ for _____
4. _____ for _____ 9. _____ for _____
5. _____ for _____10._____ for _____

List any cancers and any treatment you may have received: _____

Review of Systems: Please mark beside any problem you currently have or have had in the following categories.

Constitutional
- □Developmental Disabilities
- □Cancer
- □Fatigue Syndrome

ENT
- □Hearing Loss
- □Sinusitis
- □Dry Mouth
- □Laryngitis

Neurological
- □Multiple Sclerosis
- □Epilepsy
- □Cerebral Palsy
- □Tumor
- □Stroke/CVA
- □Migraine

Psychological
- □Depression
- □Attention Deficit
- □Anxiety Disorder
- □Bipolar Disorder

Cardiovascular
- □Hypertension
- □Stroke/CVA
- □Heart Disease
- □Vascular Disease
- □Congestive Heart Failure

Respiratory
- □Asthma
- □Bronchitis
- □Emphysema
- □Chronic Obstruction
- □Sleep Apnea

Gastrointestinal
- □Crohn's
- □Colitis
- □Ulcer
- □Acid Reflux
- □Celiac Disease

Genitourinary
- □Kidney Disease
- □Prostate Disease/Cancer

Musculoskeletal
- □Arthritis
- □Osteoarthritis
- □Fibromyalgia
- □Muscular Dystrophy
- □Ankylosing Spondylitis
- □Osteoporosis
- □Gout

Integumentary
- □Eczema
- □Rosacea
- □Psoriasis
- □Herpes Simplex/ Cold Sores
- □Herpes Zoster/Shingles

Endocrine
- □Type 1 Diabetes Mellitus
- □Type 2 Diabetes Mellitus
- □Thyroid dysfunction
- □Hormonal dysfunction

Hematologic/Lymphatic
- □Anemia
- □Large-volume blood loss
- □Ulcer
- □High Cholesterol

Allergic/Immune
- □Drug Allergies
- □Environmental Allergies
- □Rheumatoid Arthritis
- □Lupus
- □Sjogren's Syndrome

Family History

Please list parents, grandparents, siblings, or children -living or deceased with the following conditions:

□Glaucoma_____ □Diabetes_____
□Cataract_____ □Heart Disease_____
□Lazy Eye_____ □High Blood Pressure_____
□Macular Degeneration_____ □Kidney Disease_____
□Color Blindness_____ □Lupus_____
□Retinal Detachment_____ □Thyroid Disease_____

Francis Eye & Laser Center
10 Business Park Court
Utica, NY 13502
315-735-2100

Dear Valued Patient:

Your insurance plan may require member cost-sharing, which means that you may be responsible for paying a co-pay, coinsurance, or for the service itself, if you have not met your deductible.

Your plan may not cover your fees (for the reasons stated above). Please be considerate by paying promptly at a time agreed upon by you and our office.

Thank you,

Francis Eye & Laser Center

X_____ _____
Patient Signature or Guardian **Date**

Authorization to Release Information:

I hereby assign Francis Eye & Laser Center, Dr. Francis C. Migliaccio, to furnish the insured's insurance company and its agents all information which said insurance company may request concerning all claims and to release any information needed to determine benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay claims.

Assignment of insurance Benefits:

I hereby assign to Francis Eye & Laser Center, Dr. Francis C. Migliaccio all money to which I am entitled for expenses relative to all services performed from time to time, but not to exceed my indebtedness to said doctor. I understand that I am responsible to the Francis Eye & Laser Center and Dr. Francis C. Migliaccio for charges. The Francis Eye & Laser Center accepts charge determination of the insurance of the insurance carrier as full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier. I request that payment of authorized insurance benefits be made on my behalf to Francis Eye & Laser Center, Dr. Francis C. Migliaccio, for services furnished.

X_____ _____
Patient Signature or Guardian **Date**

Notice of Privacy and Acknowledgement:

I acknowledge receipt of the Notice of Privacy Practices.

X_____ _____

Patient Signature or Guardian **Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN, INTERPRETERS AND OTHERS

*PLEASE LIST NAME(S) AND RELATIONSHIP(S) BELOW:

I hereby authorize medical providers and personnel of Francis Eye & Laser Center to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I also allow my records and information to be released to the Primary Care Provider and all Specialists included in my eye care.

*PLEASE CHECK ONE BOX:

☐ All medical records and appointment information

☐ I do NOT want my information shared.

I understand that I have the right to revoke this authorization, in writing, at any time.

X_____ _____

Patient Signature or Guardian **Date**