Dr. Michelle D. Vinagre & Associates LLC, 3003-B Cranberry Highway, E. Wareham, MA 02538

PATIENT INFO

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Mailing Address: _____ Gender: M / F Occupation: _____

City/State: _____ Zip: _____ Employer: _____

Home Phone: (___) _____ Bus. Phone: (___) _____ Cell Phone: (___) _____

Email: _____ Insurance Co: _____ Ins. Subscriber: _____

Pref Language: _____ Race: _____ Ethnicity: _____ SSN: _____

Referred by: _____ HOBBIES: _____

LAST EYE EXAM DATE: _____ Eye Doctor: _____

Reason for your visit: _____

EYE HEALTH: Do you or any members of your family have any of the following vision conditions? *(Check all that apply)*

☐Blindness	☐Glaucoma	☐Macular Degeneration	☐Eye Turn/Lazy Eye	☐Cataracts
Who:	Who:	Who:	Who:	Who:

Have you experienced any of the following issues? ***(****Check all that apply****)***

☐Sudden Loss of Vision ☐Flashes of Light ☐Spots/Floaters ☐Frequent Headaches ☐Gritty Feeling

☐Double Vision ☐Eye Injury ☐Eye Surgery ☐Extreme Eye Pain ☐Dry Eye

If you chose any of the issues about please explain below:

_____

SMOKING STATUS: (*Check the ONE that applies)*

☐ Current Every day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

LAST PHYSICAL EXAM DATE: _____ Medical Doctor: _____ Where: _____

Medications: _____ Allergies: _____

_____

Do you or any members of your family have any of the following medical conditions? *(Check all that apply)*

☐Diabetes	☐High Blood Pressure	☐Heart Disease	☐Thyroid	☐Lung Disease	☐Cholesterol	☐Cancer
Who:	Who:	Who:	Who:	Who:	Who:	Who:

CONSENT TO TREATMENT

I do hereby consent to general treatment, medical procedures and medications prescribed by my doctor for purposes of my vision care.

_____

Signature of Patient ***Date***

INSURANCE ASSIGNMENT & AUTHORIZATION TO PAY FOR PROFESSIONAL SERVICES RENDERED

I do hereby certify that I (or my dependents) have insurance coverage with _____ and assign directly to Dr. Michelle Vinagre, Optometrist ("the Provider") all insurance benefits, if any, for all professional services rendered. I understand that the Provider will file an insurance claim, if applicable, on my behalf with my insurance company. I acknowledge that my insurance company may not pay for all care, tests or procedures that the Provider may recommend based on their professional expertise. I fully understand that I am financially responsible for all charges for professional services rendered whether or not paid for or covered by my insurance company. I acknowledge that I have been given the opportunity to ask the Provider any questions I had pertaining to all the professional services rendered by the Provider. Furthermore, I acknowledge that the Provider cannot accept any responsibility for collecting my insurance claim or for negotiating a settlement on any disputed claim. **SHOULD FOR ANY REASON MY INSURANCE CLAIM BE DENIED OR UNPAID, I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY PROFESSIONAL SERVICES RENDERED NOT PAID BY MY INSURANCE COMPANY.** ***I understand that should I fail to pay any amounts due and payable for professional services rendered that the Provider may submit my account to collections which will incur an additional collections fee of $25 on my account in addition to any additional fees, interest, or costs imposed as part of collecting my account.*** I hereby authorize the Provider to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I authorize any interested party to accept copies of this form as though they were the original forms signed and executed by me.

_____

Signature of Patient ***Date***

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Lifestyle Questionnaire

Please answer the following questions about your needs so that we can best assist you in choosing the eye wear that is right for you and your lifestyle.

1. How many pairs of glasses do you currently own, including sunglasses?_____

2. What do you like or dislike about your current glasses?

_____
_____.

3. What type of work do you do?

_____
_____.

4. What activities/hobbies/sports do you participate in? Indoor and Outdoor.

_____
_____.

5. How many hours a day do you spend on a computer, smart phone, tablet/iPad or other similar devices?_____

6. Do you have any allergies to metal and/or silicone?: _____Yes ____No *If Yes, which*?:_____.

7. Are you bothered by glare from any of the following? *Check all that apply*

_____Headlight from oncoming vehicles	_____Night driving
_____Computer screen	_____Snow
_____Bright sunshine	_____Fluorescent/overhead lighting

8. Do you currently wear contact lenses?___Yes____No

9. If you answered "No" to the previous question, would you be interested in trying contact lenses?Yes____No

10. Are you interested in having an **iWellness™** screening today? ____Yes____No

This is a quick non invasive scan that allows the doctor to see below the surface of your retina to detect any vision threatening and systemic diseases in their very early stages, when they are most treatable. This will be a $20 charge, not covered by your insurance, that will be added into the cost of your visit today.