Contact Lens Information

Type you currently wear: _(soft/rigid/other)_____

If known, brand name lens you wear: _____
If you have your contact lens packaging please present to the doctor for complete info.

How many years have you worn this type of lens: _____

Frequency of lens replacement: Prescribed:_____ Actual:_____
Hours/day wear typically: _____ Number of hours worn today: _____
Do you sleep in your lenses: No ☐ Yes ☐
If yes, how frequently? _____

Name of contact lens solutions you use: _____
Do you rub your lenses to clean them before putting in case: No ☐ Yes ☐

Any problems with lenses, such as with vision or comfort, such as dryness, seasonal ocular allergy issues: _____
_____
_____
_____

Are there specific contact lenses you have questions about, such as daily disposable or bifocal?
_____
_____

Contact Lens - History:
Summary of significant problems in past, reasons for lens refits, such as from hard to soft:
_____
_____
_____
_____
_____
_____

You can email this form to [illegible]visusci.com or fax to 877 751-9156. If you are unable to do that please bring it to your appointment.

When was your last eye exam? _____ How old are your eyeglasses? _____

Reason for today's visit: _____

Ocular History (List past and present information):
Record any eye related problems or injuries you have, such as "lazy eye", amblyopia, astigmatism, glaucoma, cataract, conjunctivitis, dry eye, etc., and any eye surgeries.

Family History:			Relationship to Patient:
Diabetes	No ☐	Yes ☐	
Glaucoma	No ☐	Yes ☐	
High Blood Pressure	No ☐	Yes ☐	
Retinal Detachment	No ☐	Yes ☐	
Macular Degeneration	No ☐	Yes ☐	
Dry Eye	No ☐	Yes ☐	

List, or Provide List of, Current Medications and Dose: ☐ No current meds

Allergies, including to medications, seasonal, and any treatments: ☐ No known allergies

List systemic illnesses/conditions:

List Hobbies/activities:

Computer use: ☐ <1 hr/day ☐ 1-3 hr/day ☐ 3-8 hr/day ☐ >8 hr/day

IF YOU WEAR CONTACT LENSES PLEASE ALSO COMPLETE NEXT PAGE

You can email this form to cleahy@vistasci.com) or fax to 877 751-9156. If you are unable to do that please bring it to your appointment.

Charles D. Leahy, O.D., M.S.
Assistant Professor of Ophthalmology, Harvard Medical School
Optometry, Contact Lenses
(PLEASE COMPLETE ALL ITEMS IN LEGIBLE PRINT)

Date: ___/___/____

PATIENT INFORMATION

Name: _____ Date of Birth ___/___/____ Sex: M F
Street: _____ Phone: Home: _____
City: _____ Work: _____
State: _____ Zip code: _____ Cell: _____

E-mail address: _____

Preferred contact for reminders, messages: e-mail phone

Primary Care Physician (PCP): _____ Address: _____

_____

PCP Phone: _____ PCP Fax: _____

Occupation: _____ Employer/school: _____

Health Insurance: _____ Policy/Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Vision Plan, if applicable: _____ Policy/Group Number: _____

Referred by: _____

Family members treated by this office: _____

Emergency contact : _____

Financial responsibility (name and address if different from above): _____

_____

PLEASE ALSO COMPLETE NEXT PAGE

AUTHORIZATION FOR TREATMENT AND PAYMENT

I hereby consent to my examination and treatment in the office of Dr. Leahy. I authorize the doctor to obtain from other hospitals and physicians, records of my medical treatment. We must emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services were rendered.

I understand that I am financially responsible for any services **not** covered or allowed, but not paid, due to the terms of my insurance coverage. I understand that it is my responsibility to comply with the guidelines set by my insurance company, such as ensuring eligibility at the time of service and obtaining prior authorizations.

I understand that all co-payments, deductibles, and non-covered charges are due at the time of service or immediately upon insurance provider determination at a later date after claim processing, which can take months.

I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approval for medical visits. I understand that I have an obligation to obtain any necessary referrals for specialist services from my primary care physician (PCP) **prior** to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.

If uninsured, full payment for all services is due on the date of service. I understand that future appointments may be contingent upon having met my financial obligations within the office. In addition, I understand that I am responsible for any balance of the bill that the insurance company does not pay.

Specifically, insurance often considers eyeglass refractions and contact lens care and supplies "non-covered" services, separate from routine eye exam charges and services, and I will be responsible for payment.

Vision plan patients: I understand that discount vision plans are not medical insurance, apply to routine annual eye exam services only, and are not applicable for problem visits or medically indicated services, and that I am responsible to pay for these services and to provide any medical insurance coverage information. I authorize release of any medical information necessary to process insurance claims for services rendered to me and request payments of insurance benefits for services rendered me to be paid directly to Dr. Leahy's office.

I acknowledge that I received a copy of Charles D. Leahy, O.D., M.S. Notice of Privacy Practices.

Signature of patient or parent/guardian: _____