WELCOME

Thank you for trusting us with your eye & vision care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to ask us.

A PATIENT INFORMATION

Date _____
Patient _____
Address _____
City/Town _____
Email Address _____
Sex: M ☑ F ☑ Age _____ DOB _____

Single ☐ Married ☐

SS# _____
Occupation _____
Employer _____

Employer Address _____
_____
Employer Phone _____

Spouse's Name _____

C PHONE NUMBERS

Home _____
Work _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____
Relationship _____
Home Phone _____
Work Phone _____

D Protected Medical Information

I authorize release of any medical information to my insurance company, legal counsel, Worker's compensation insurance company or liability insurance company for the purpose of pre-certification or to process my insurance claims. I also authorize the release of my medical records to any physician that is involved in my healthcare.
(Signature) _____ Date _____

B INSURANCE

Who is responsible for this account? _____
Relationship to patient _____
DOB _____ SS# _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? y ☐ n ☐
Subscriber Name _____ ☐ ☐
DOB _____ SS# _____
Relationship to patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I or my dependents have insurance coverage with _____ and assign directly to **Dr. Robert J. Bolduc** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
(Responsible Party Signature)

_____
(Relationship)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Robert J. Bolduc** for any services furnished me.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

_____ _____
Beneficiary Signature Date

Medical History

Name:_____ Date:_____

Birth Date: _____/_____/_____ Social Security #: _____ Last Eye Exam:_____

Medical Doctor: _____ Practice name:_____

Practice Phone : _____

Medical History:

Do you have any allergies to medications? Please list:_____

_____

_____

List (or provide a list of) any medications you take. Include dosage and frequencies: _____

_____

_____

_____

_____

_____

_____

Ocular History:

List any eye conditions you may have had: (crossed eye, lazy eye, dry eyes, glaucoma, retinal disease, infections, or eye injuries:

_____

_____

Do you wear glasses? **YES / NO** (circle one) Do you wear contact lenses? **YES / NO** (circle one)

What type of contact lenses:(daily,monthly,gas perm/scleral) _____

How often do you change your contact lenses? _____ Cleaning Solution: _____

List any eye surgeries you may have had in the past: (Lasik, cataracts) Please list location, surgeon, and dates: _____

_____

_____

_____

Review of Systems: Do you currently, or have you ever had recurrent problems in the following areas: (Please Circle)

Eyes :

Loss of vision
Blurred vision
Distored Vision/Halos
Loss of Side Vision
Redness
Sties/Chalazion
Burning
Foreign Body Sensation
Excess Tearing/Watering
Double Vision
Sandy/Gritty Feeling
Flashes/Floaters
Glare/Light Sensitivity
Eye Pain/Soreness
Chronic Infection of Eye/Lid
Dryness
Itching
Tired Eyes

Ear Nose/Throat/Mouth :

Allergies
Sinus congestion
Dry Throat/Mouth
Hearing Loss
Runny Nose

Mental Health:
Allergies
Depression
Bipolar Disorder
Schizophrenia

Respiratory:
Asthma
Chronic Bronchitis
Emphysema
COPD
Sarcoidosis

Endocrine:
Thyroid
Pituitary

Vascular/Cardiovascular:
Diabetes
Atrial Fibrillation(A-Fib)
High Blood Pressure
Cholesterol
Stroke
Coronary Artery Disease

Cancers:
Leukemia
Breast
Colon
Skin
Lung

Autoimmune Diseases:
Lyme Disease
Lupus
Sjogren's Syndrome
Multiple Sclerosis
Rheumatoid Arthiritis

Mental Health:
Anxiety
Depression
Bipolar
Schizophrenia

Neurological:
Headaches
Migraines
Seizures

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

	RELATIONSHIP TO YOU:
Blindness	
Cataract	
Crossed Eyes	
Glaucoma	
Macular Degeneration(wet/dry)	
Retinal Detachment/Disease	
Arthritis	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Lupus	
Thyroid Disease	
Other: _____	

ADDITIONAL NOTES / OTHER CONCERNS OR CONDITIONS WE SHOULD BE MADE AWARE OF:

Insurance and Financial Policies

- I agree to pay the estimated co-pay at the time of service. *I understand this is **not** a guarantee of benefits.*
- I understand that you will submit my claim to my primary insurance as a courtesy to me.
- I agree to pay any balance remaining once my insurance claims have been processed.
- I authorize insurance payment directly to Bolduc Eye Care.
- If I am not covered by insurance, I agree to pay for each appointment in full at the time of service with cash, local check, CareCredit, MasterCard, Visa, or Discover Card.

Exchange Policy

- If you are unhappy with your glasses, please notify us within 30 days. Our labs have a strict policy on remakes. They allow 1 remake within 30 days at no cost.
- Any changes after 30 days will be done at 50% of the original cost of the lenses.
- Eyeglasses are custom made for each individual and are considered a medical prescription. They cannot be returned for a **full** refund.
- We will remake your glasses covered under the one-time, no-fault guarantee within 30 days.
- If you are unhappy with your frames, we will allow one re-style within 30 days, otherwise, all sales are final.

Signed:_____Date:_____