



Envisions Eyecare Centers, Inc

Elegance N Eyewear Boutique

EAST PROVIDENCE
1970 Pawtucket Avenue
East Providence, RI 02914
(401) 438-1166 (Tel.)
(401) 438-1614 (Fax)

PROVIDENCE
319 Pocasset Avenue
Providence, RI 02909
(401) 942-1444 (Tel.)
(401) 223-7149 (Fax)

CRANSTON
868 Reservoir Avenue
Cranston, RI 02910
(401) 942-9933 (Tel.)
(401) 270-2491 (Fax)

Dr. John S. Corvese and Associates
Dr. Jared Scaramuzzi **Dr. Harrison T. Smiley**
Dr. Norma Swenson **Dr. Maria Serio**
www.envisionseyecare.com

WEST WARWICK
328 Cowesett Avenue
West Warwick, RI 02893
(401) 821-4300 (Tel.)
(401) 381-0084 (Fax)

NORTH PROVIDENCE
1543 Smith Street
North Providence, RI 02911
(401) 353-2010 (Tel.)
(401) 353-0380 (Fax)

Courtesy Office Visit Reminder:

Please Bring in Your

- Completed or Updated Medical History Form (forms are required to be updated every two years)
 - Current Glasses including reading glasses, computer glasses, sunglasses.
 - Current Contact Lenses Prescription or box
 - Health Insurance Card
 - Photo ID
-

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Birth Date: _____ Social Security #: _____ Cell Phone: _____

Sex: _____ Last Eye Exam: _____ Email Address: _____
(Email is recommended for reminders such as; routine exam, glasses and contact lens pickup)

If patient is a minor, please indicate parent/guardian name(s): _____

Name of Primary Doctor: _____ Dr.'s Phone: _____

Name of Secondary Doctor: _____ Dr.'s Phone: _____

REASON FOR TODAY'S VISIT: routine visit eye problem glasses contacts CRT Lasik Surgery
Referred by _____

Are you pregnant and/or nursing: no yes

Do you wear glasses: no yes If yes, how old is your present prescription? _____

Do you wear contact lenses? no yes If yes, how old is your present prescription? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

MEDICAL HISTORY

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

** PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO **

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer. Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type / amount / how long: _____
 Do you drink alcohol? no yes If yes, type / amount / how long: _____
 Do you use illegal drugs? no yes If yes, type / amount / how long: _____
 Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	NO	YES	?
CONSTITUTIONAL						
Fever, Weight Loss/Gain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY (Skin)						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NEUROLOGICAL						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EYES						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing / Watery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sties or Chalazion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENDOCRINE						
Thyroid / Other Glands.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EARS, NOSE, MOUTH, THROAT						
Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIRATORY						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
VASCULAR / CARDIOVASCULAR						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GASTROINTESTINAL						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY						
Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
BONES / JOINTS / MUSCLES						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle / Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
LYMPHATIC / HEMATOLOGIC						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ALLERGIC / IMMUNOLOGIC						
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

ENVISIONS EYECARE CENTERS POLICIES

By signing this form, I knowingly agree to and understand the following terms:

1. All charges for services are due at the time of service. New patients who do not have insurance card/information will be responsible for services that day.
2. If your insurance requires a referral, it is YOUR responsibility to obtain one PRIOR to services. If a referral is not obtained, you will be responsible for any charges incurred for your visit.
3. All copays are due at the time of visit. All unpaid copays will be billed to the patient and will include a \$10.00 billing fee unless specific prior arrangements have been made and approved.
4. All VISION INSURANCE purchases will require a 100% deposit. All NON-VISION INSURANCE will require 50% and must be paid in full at pickup. We will hold all eyeglass/contact lens orders for 90 days. After the 90 days, CONTACT LENSES will be returned for credit and the patient will incur a 15% restocking fee. EYEGLASSES will be dissembled and the DEPOSIT will not be refunded to the patient.
5. Our frames are priced to reflect a 20% discount off suggested retail prices. This discount may not be combined with any discount that may be offered by your insurance.
6. Any portion of my bill not paid by my insurance is my full responsibility. Balances left unpaid after 30 days will be subject to an 18% interest rate fee as well as a \$10 monthly billing fee. Delinquent accounts will be sent to a collections attorney, and I will be responsible for my balance as well as any applicable legal fees.
7. Any new or existing patients that do not cancel their appointment within 24 hours in advance will be charged a **NO SHOW/CANCELLATION FEE of \$55.00**.
8. **SPECTERA/OPTUM, DAVIS VISION, EYEMED AND VSP.** Your insurance company provides your glasses/contact lenses. Envisions Eyecare Centers, Inc. and Elegance N Eyewear are not responsible for any additional services beyond that provided in your policy. Rechecks, Do-over prescriptions and defective replacement will incur an additional fee(s). Refunds are not allowed per your insurance policy. Please refer to your insurance for details.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read, received, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient/Guardian (Signature) _____ **Date** _____

Print Full Name of Patient _____