DuPage Eye Center **1001 Ogden Ave., Downers Grove, IL 60515**

Patient Name: _____ Gender: M F

Date of Birth: _____ Social Security Number: _____

Address: _____

Home Phone: ( ) _____ Work/Cell: ( ) _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone: _____

Who referred you to our Office? _____

Primary Physician Name and phone number: _____

Who is your Optometrist? _____

When was your last eye exam? _____ Do you wear: Glasses Contacts Both

POLICYHOLDER INFORMATION: *** **HMO: YES NO** ***

Primary Ins.: _____ Secondary Ins.: _____

Responsible Party: _____ Phone: _____

Address: _____

Date of Birth:_____ Social Security Number: _____

- Co-pays need to be paid at time of service.
- The test performed to measure for eyeglass prescriptions is called a **REFRACTION** and is **NOT** covered by insurance. **Patients are responsible for the $35.00 fee AT THE TIME OF SERVICE.**
- ***HMO** patients must give their referral to the receptionist upon arrival. Patients who do not have their referral may either reschedule their appointment for a later date or make payment for the services rendered. ***
- We file to insurance companies as a courtesy to our patients. Patients are ultimately responsible for following up with insurance companies and notifying us of any changes. Any "patient responsible" charges (co-payments, deductibles and coinsurance) are due at the time of service.

I, the undersigned, have insurance coverage as stated above, and hereby directly assign to DuPage Eye Center all surgical and/or medical 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 any information necessary to secure payment of benefits.

_____ _____

Signature (if patient is a minor, parent signature) (Date)

WHAT PROBLEMS ARE YOU CURRENTLY HAVING WITH YOUR EYES?

Loss of peripheral vision	N	Y	Blurred vision	N	Y
Fluctuating vision	N	Y	Distorted vision	N	Y
Double vision	N	Y	Dryness	N	Y
Mucus discharge	N	Y	Redness	N	Y
Sandy or gritty feeling	N	Y	Itching	N	Y
Burning	N	Y	Foreign body sensation	N	Y
Tearing/watering	N	Y	Glare/Light sensitivity	N	Y
Eye pain/soreness	N	Y	Eyelid lump or bump	N	Y
Tired eyes	N	Y	Crossed/lazy eye	N	Y
Drooping lids	N	Y	Floaters/grey spots	N	Y

Any past diagnosis of: Glaucoma? N Y **Cataract?** N Y **Retinal Problems?** N Y

HAVE YOU HAD ANY PAST EYE SURGERIES, LASER TREATMENTS, OR INJURIES? N Y
EXPLAIN: _____

DO YOU HAVE ANY HISTORY OR CURRENT PROBLEMS/SURGERIES IN THESE AREAS?			
	Yes	No	Explain
Constitutional (weight loss, fever)			
Ears, nose, throat (ear infections, tonsillectomy)			
Cardiovascular (high blood pressure, heart attack)			
Respiratory (asthma, emphysema)			
Gastrointestinal (ulcers, gout)			
Genital, (Nephrology) Kidney, Bladder (incontinence, infections)			
Muscles, Bones, Joints (arthritis, joint surgeries)			
Skin (acne, warts, skin cancer)			
Neurological (multiple sclerosis, Parkinson's)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, thyroid imbalance)			
Blood/Lymph (high cholesterol, anemia)			
Allergic/Immunologic (allergies, lupus, Sjogren's)			
Cancer			

Do you have or use the following (please circle): **Pacemaker** **Defibrillator** **Oxygen**
Do you have **Chronic Obstructive Pulmonary Disease (COPD)**? N Y

DO YOU: Drive? N Y Smoke? N Y Drink alcohol? N Y

ANY FAMILY HISTORY OF:

Glaucoma?	N	Y, Who_____	Arthritis?	N	Y, Who_____
Macular Degeneration?	N	Y, Who_____	Lupus?	N	Y, Who_____
Retinal Detachment?	N	Y, Who_____	Thyroid Disease?	N	Y, Who_____
Cancer?	N	Y, Who_____	Heart Disease?	N	Y, Who_____
Diabetes?	N	Y, Who_____	High Blood Pressure?	N	Y, Who_____

Please list **ALL** medications you are taking, including over- the-counter supplements and herbs:

Are you allergic to any medications? If yes, please list:

PATIENT
FINANCIAL OBLIGATION

I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility of collecting my insurance claims or for negotiating a settlement on disputed claims.

I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a total of two statements for any balance due by me before a mandatory -full payment- letter is initiated by DuPage Eye Center.

I agree to pay any unpaid balance due and owing on my account within THIRTY (30) DAYS from the date of the initial statement.

Further, I agree that any portion of my account which remains unpaid after the passage of SIXTY (60) DAYS from the date of the first monthly statement shall be considered "delinquent" for the purposes of collection and shall bear interest at a rate of FIFTEEN PERCENT (15%) per annum until paid in full.

If any portion of my account becomes delinquent and it becomes necessary for the provider to refer this matter to an attorney for collection, **I agree to pay the reasonable attorney fees, costs and expenses incurred through and/or other efforts to collect the delinquent sums**.

_____ _____

Patient Signature Date