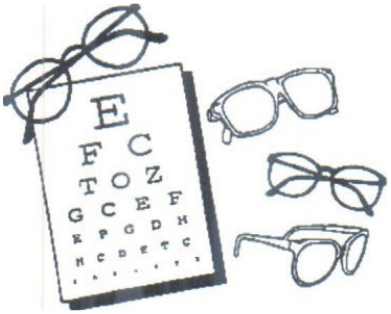

PATIENT INFORMATION

Today's Date:

PATIENT INFORMATION

Name: Last First: Middle:

Address: City: State/ZIP:

Phone: Home: Cell: Work:

E-mail

Birthdate Social Security #

Gender: Marital Status: Race/Ethnicity:

Occupation Employer

If a student, School Name School Address

Grade Mother's Name Father's Name

RESPONSIBLE PARTY INFORMATION (COMPLETE IF DIFFERENT THAN PATIENT)

Responsible Party's Full Name Relationship to Patient

Address: City: State/ZIP:

Phone: Home: Cell: Work:

INSURANCE INFORMATION

Primary Insurance Group #

Address ID#

Subscriber Subscriber's Birthday

Employer

EYE HISTORY

Date of last exam

Do you currently wear glasses? ◯ Do you currently wear contact lenses? ◯

Did you ever have eye surgery, eye disease or any eye injury?

If yes, please explain

Does anyone from your blood-related family have any history of eye disease or eye surgery?

If yes, please explain

HEALTH HISTORY

What is your general health?

Do you have problems with any of these systems? (check all that apply)

Gastrointestinal ◯	Nervous ◯	Mental ◯
Ears/Nose/Throat ◯	Genitourinary ◯	Endocrine (glands) ◯
Cardiovascular ◯	Musculoskeletal ◯	Blood/lymph ◯
Respiratory ◯	Integumentary (skin) ◯	Allergic/immunologic ◯

Please explain:

Please answer all that apply:

Diabetes ◯ Type Date of Diagnosis

Allergies ◯ Allergic to what? What happens?

Medication allergy ◯ What happens? Headaches ◯

Current medication(s)

Name of primary doctor: Date of last visit to primary doctor:

Doctor's address: Phone #

HEALTH HISTORY

High blood pressure ◯ Relationship?

Diabetes? ◯ Relationship?

Thyroid condition? ◯ Relationship?

FINANCIAL ASSIGNMENT & AGREEMENT

1) I authorize Dr. Niemczyk & Associates to file insurance claims on my behalf and accept benefits when appropriate. I also authorize release of any information to determine these benefits by the insurance company.
2) It is my responsibility to pay any balance not paid by my insurance, such as non-covered routine eye exam, deductible, co-insurance or refraction (the part of the exam that determines eyeglass prescription).
3) Should I be a Medicare beneficiary, I understand that the refraction (the part of the eye exam that determines eyeglass prescription) is a non-covered service.
4) If my insurance requires a referral to allocate payment to Dr. Niemczyk & Associates and I do not have a referral at the time of services, or I do not present an appropriately dated referral within one week from time of services, I will accept financial responsibility.
5) Should I present Dr. Niemczyk & Associates with incorrect insurance information at the time of services. I understand that Dr. Niemczyk & Associates will not be responsible for submitting additional claims and that I will accept financial responsibility.
6) Any optical appliance prescribed by Dr. Niemczyk & Associates will require payment in full or a 50% deposit at the time of ordering. Any remaining balance must be satisfied before the optical appliance will be dispensed.
7) I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars ($50.00) or 20% of the balance owed, whichever amount is greater.

PRINT NAME:

SIGNATURE: DATE:

Executive Eye Associates

Optomap Retinal Imaging

Optomap retinal imaging allows our office to offer the latest technology for a more comprehensive way of viewing the inside of your eyes, your retina, by just the click of a camera. It is a quick, easy and painless procedure.

This test is invaluable in detecting peripheral defects of the eyes and monitoring eye diseases, such as glaucoma, diabetic retinopathy or macular degeneration, and detecting diseases of the body including diabetes, high blood pressure, and high cholesterol.

Optomap is highly recommended for anyone with a family history of the above diseases, is very nearsighted, has a history of trauma or has never had a complete eye exam.

The fee for this procedure is $29 and may be covered by insurance if one of the above conditions is present. Your doctor will go over the image with you in depth and let you know if it will be covered at that time.

Since our office staff performs this test prior to the exam, please tell our front desk staff if you would like to have this procedure performed. If you have any questions, the doctor will be happy to discuss this in more detail.

I APPROVE OF AN EXTRA $29 FEE FOR THIS PROCEDURE. _____

(SIGNATURE & DATE)