Gainesville Eye Associates
7300 Heritage Village Plaza, Suite 101
Gainesville, VA 20155
Tel: (703) 753-4733 Fax: (703) 753-2183

Dear Patient: : "Most Insurance Companies will not pay for a Complete Eye Exam with an OPHTHALMOLOGIST unless it is due to a medical illness or injury."

Date_______________

Last Name___________________________ First Name__________________ Middle Initial__________

Age_________ Gender_________ Birth Date__________________ SS#_____________________________

Address____

City ____________________________________ State_________________________ Zip_______________

Home Phone __________________________________ Work Phone________________________________

Mobile Phone__________________________________ E-Mail Address______________________________

Emergency Contact Name & Phone#____

Primary Care Doctor, City & Phone #____

Pharmacy, Address & Phone#____

How did you hear about us? ____

** If the Patient is a Minor, List the Parent or Guardian's Name____________________________________*

** If the Patient is not the Sponsor in the Insurance Card, please provide the following:*

Sponsor's SSN______________________________________ Sponsor's Date of Birth___________________

BY SIGNING BELOW , I HEARBY AUTHORIZE:

- My consent for medical treatment by the Doctor/Gainesville Eye Associates Staff & Acknowledge no guarantees have been made regarding the results of treatment/exam.
- Payment from my insurance company to Gainesville Eye Associates for medical treatment.
- The release of medical information to/from the insurance for claims processing.
- I will be responsible for all charges not paid by my insurance, including refraction fees.
- I will be responsible if I did not obtain a referral or authorization from my insurance Company Or Primary Care physician.
- List names of people we may give your PRIVATE HEALTH INFORMATION to:

____

____

- *Permission to leave a reminder for appointments on my answering machine or voicemail.*
- *If I do not provide at least a 24 hour advance notification for canceling or rescheduling an appointment, I may be charged a fee of $50.00.*

_____________________________________ ______________________

Signature of Patient or Patient's Guardian Date

Gainesville Eye Associates
Philip R. Chung, M.D.
General Ophthalmology
Diplomate of the American Board of Ophthalmology

CONSENT FOR REFRACTION AND GLASSES PRESCRIPTIONS

Refraction is the test that is performed to determine your eyeglass prescription. Refraction may be performed by either the doctor or a technician, and typically involves questioning along the lines of, "Is 1 better than 2?" Refraction enables the doctor to write a prescription for glasses.

Medicare and many other insurance plans will not cover refractions; this amount is charged separately and is the patient's responsibility. Also Medicare secondary insurance plans will not pay the charge since it is not a Medicare-covered service. The fee of **$35.00** is to be paid by the patient.

In the event that a patient is dissatisfied with an updated prescription and an attempt has been made to adjust the prescription and the optical shop has confirmed the glasses were made correctly, an appointment for a glasses check can be scheduled at no extra charge. However, refunds are not offered on prescriptions that require further adjustment.

Please sign below stating that you have read and understand the above information.

____ ___________________

Signature Date

7300 Heritage Village Plaza – Suite 101 – Gainesville, VA 20155
Phone 703-753-4733 – Fax 703-753-2183

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ **Date of Birth**: ____________________

Ethnicity	Race	
____ Hispanic	____ American-Indian / Alaska Native	
Not Hispanic	____ Asian	____Middle Eastern
Preferred Language	____ Black / African American	____Native Hawaiian or Other Pacific Islander
____ English	____ East Indian	____White
____ Spanish	____ Hispanic or Latino	____Other
Other:______________		

Allergies (drug, seasonal, environmental)	Reaction (circle one)	None Known
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	

Past Ocular History: (Please mark all that apply and indicate which eye)

____ Overall Healthy	____ Cataracts	____ Herpes	____ Macular Degeneration
____ Amblyopia (Lazy eye)	____ Diabetic Retinopathy	____ Hyperopia (Far sighted)	____ Myopia (Near sighted)
____ Aphakia	____ Dry Eyes	____ Iritis	____ Optic Neuritis
____ Astigmatism	____ Glaucoma	____ Keratoconus	____ Retinal Detachment

Past Ocular Surgeries: (Please mark all that apply and indicate which eye and dates)

____ No prior ocular surgery	____ Foreign Body Removal	____ PRK	____ Trabeculectomy (glaucoma)
____ Blepharoplasty	____ (Retinal) Laser Surgery	____ Punctal Plugs	____ Vitrectomy
____ Cataract Surgery	____ (Glaucoma) Laser Surg	____ RK	____ YAG Capsulotomy
____ Corneal Transplant	____ LASIK	____ Strabismus Surgery (eye muscle)	

Current EYE Medications: (Please list)

____
____
____

Past Medical History:

____ No history of illness	____ COPD	____ High Cholesterol	____ MRSA
____ Anemia	____ Diabetes - Type I / II	____ HIV / AIDS	____ Polymyalgia
____ Arthritis	____ Eczema	____ Kidney Disease	____ Psychiatric Disorder
____ Arrhythmia	____ Fibromyalgia	____ Kidney Stones	____ Skin Cancer
____ Asthma	____ Headache	____ Liver Disease	____ Sjogrens
____ Bleeding Disorder	____ Hearing Loss	____ Lung Disease	____ Stroke
____ Cancer	____ Hepatitis A / B / C	____ Lupus	____ Syphillis
____ Chicken Pox	____ Herpes Zoster / Shingles	____ Migraine	____ Toxoplasmosis
____ Congestive Heart Failure	____ High Blood Pressure	____ Multiple Sclerosis	____ Wound Infection

Current Other Medications: (Please list)

____
____
____

PLEASE CONTINUE ON THE BACKSIDE OF THIS PAGE ------->

Past Surgeries / Operations: (Please list)

____

____

____

Family History: (siblings, parents, grandparents)

	Relationship	Living (circle one)		Relationship	Living (circle one)
____ Diabetes	____________________	Yes or No	____ Blindness	__________________________	Yes or No
____ Cancer	____________________	Yes or No	____ Cataract	__________________________	Yes or No
____ Heart Disease	_______________	Yes or No	____ Glaucoma	__________________________	Yes or No
____ Stroke	____________________	Yes or No	____ Macular Degeneration	_______________	Yes or No
____ TB	______________________	Yes or No	____ Retinal Disease	___________________	Yes or No
____ Kidney Disease	______________	Yes or No	____ High Blood Pressure	_________________	Yes or No
____ Arthritis	____________________	Yes or No	____ Lazy Eye	__________________________	Yes or No
			____ Thyroid Disease	____________________	Yes or No

Social History: (Please mark all that apply)

____ Smoking: ____ current every day smoker ___former smoker ____ never smoked

____ Alcohol Use: ____ Yes ____ No If yes how much and how often? ______________________

____ Drug Use: ____ Yes ____ No If yes what and how often? ____________________________

Review of Systems: (Please mark all that CURRENTLY apply)

Eyes

____ Previous Surgery
____ Contact Lens
____ Pain
____ Double Vision
____ Glaucoma
____ Cataracts
____ Macular Degeneration
____ Dry Eyes
____ Flashes
____ Floaters

Ear, Nose, and Throat

____ Hard of Hearing
____ Ringing in Ears
____ Vertigo

Cardiovascular

____ Chest Pain
____ Dizziness
____ Fainting Spells
____ Shortness of Breath
____ Irregular Heart Beat
____ Difficulty Lying Flat

Constitutional

____ Fatigue / Weakness
____ Fever
____ Weight Gain / Loss

Respiratory

____Cough
____Congestion
____Wheezing
____Asthma

Gastrointestinal

____Heartburn
____Nausea / Vomiting
____Jaundice / Hepatitus

Genito-Urinary

____Pain / Difficulty
____Blood in Urine
____History of Kidney Stones
____History of STD's

Psychiatric

____Anxiety / Depression
____Mood Swings
____Difficulty Sleeping

Endocrine

____Increased Thirst
____Increased Hunger
____Increased Urination
____Increased Sweating
____Fingernail Changes

Blood / Lymphnodes

____ Easy Bruising
____ Gums Bleed Easily
____ Prolonged Bleeding
____ Heavy Aspirin Use

MusculoSkeletal

____ Stiffness
____ Arthritis
____ Joint Pain / Swelling

Skin

____ Rash / Sores
____ Lesions
____ Hives / Eczema

Neurological

____ Seizures
____ Weakness / Paralysis
____ Numbness
____ Tremors

Immunologic

____ Itching
____ Runny Nose
____ Sinus Pressure

Other ____