WESTWOOD
EYE CARE & OPTICAL

YOUR VISION. OUR FOCUS.

DR. CORY LAVALLEE, OD
DR. MICHAELA TEMPLE, OD

738 High Street
Westwood. MA 02090
Telephone (781) 329-5454

Patient Name: _____ Date of Birth: _____ Sex: M F

Street Address: _____ **Email Address:** _____

City, State, Zip Code: _____

Social Security#: _____ Home Phone: _____ **Cell Phone:** _____

Vision Insurance: _____ Number: _____ CoPayment: _____

Subscriber's Name: _____ Relationship to Patient: Self Spouse Parent Other

Subscriber's Social Security #: _____ Subscriber's Date of Birth: _____

Medical Insurance: _____ Insurance Number: _____

Subscriber's Name: _____ Relationship to Patient: Self Spouse Parent Other

Primary Care Provider: _____ Phone Number: _____

PCP Address: _____

Premium Eye Care, P.C. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. You have the right to review this notice prior to signing this acknowledgment. The terms of the notice may change with time and we will always post the current notice at our facility, on our web site, and have copies for distribution.

I acknowledge that I have been given the opportunity to receive, review and ask questions regarding Premium Eye Care, P.C. Notice of Privacy Practices.

I authorize Premium Eye Care, P.C. to release any information requested by my insurance carrier, relative to processing this claim.

I hereby assign Premium Eye Care, P.C. all payments for medical services and/or Optical products rendered.

I understand that my insurance carrier may not cover the cost of my care in whole or in part. I acknowledge that this has been explained to me. I further understand that some necessary procedures and products may not be reimbursable from my insurance company, or from Federal programs such as Medicare and Medicaid.

I understand that some services may require approval from my primary care physician for coverage and if I do not obtain that approval, I am financially liable for the services.

I agree that I am financially responsible for all charges not covered by the Insurance. I further agree to pay any balance immediately upon notification from Premium Eye Care, PC.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Employer (or School) _____ Occupation (or Grade) _____

Spouse (Parent Name) _____ Children's names/ages _____

Family members examined in this office: _____

Date of last Eye Exam _____ By _____

Major Reason for this visit: _____

The signs and symptoms of many systemic disorders can be detected during your routine eye examination today, and effect our findings. Please check any of the following conditions that you now have or have been treated for in the past.

- ❑ Gastrointestinal
- ❑ Nervous System
- ❑ Mental
- ❑ Ear/Nose/Throat
- ❑ Genitourinary
- ❑ Endocrine (Glands)
- ❑ Cardiovascular
- ❑ Musculoskeletal
- ❑ Blood/Lymph
- ❑ Respiratory
- ❑ Skin
- ❑ Allergic/Immunologic
- ❑ Headaches
- ❑ Surgeries (what type & when)_____

Please List:

Medications/Vitamins _____ Are You Pregnant/Nursing _____

Allergy to Medications _____ Do You Smoke/Drink Alcohol? _____

Oral Contraceptives _____

Your doctor will be checking for all of the following eye conditions during the examination today. Please circle any of these that any other doctor has previously detected, or you feel you are at risk to develop.

Melanoma	Cataract	Glaucoma	Hyperopia
Macula Degeneration	Dry Eye Syndrome	Amblyopia	Myopia
Vitreous Detachment	Retinal Detachment	Basal Cell Carcinoma	Astigmatism
Retinitis Pigmentosa	Diabetic Retinopathy	Night Blindness	Presbyopia
Computer User Syndrome	Allergic Eye Syndrome	Other _____	

It is helpful to know which activities you enjoy so that we may better serve your visual needs. Please circle all that apply:

Fishing	Flying	Driving	Hunting	Shooting	Computers	Reading
Biking	Aerobics	Playing Cards	Sewing	Crafts	Golf	Cooking
Gardening	Skiing	Boating	Scuba Diving	Walking/Jogging	Tennis	Other_____

Do you Work at a computer for long periods? Y N

Are you interested in thinner, lighter eyeglass lenses? Y N

Interested in Contacts? Y N

Do you wear bifocals? Y N

Interested in Refractive Surgery? Y N

Payment & Refund Policy:

Payment is expected at the time services are rendered. A deposit is required before materials can be ordered.

Your eyeglasses are custom made using your prescription, in the frame you have chosen. Once they have been made, refunds for eyeglasses are not allowed. If a problem arises, we will gladly modify a lens (or lenses) as needed, at no cost to you. Thank you for your understanding.

Payment Method: Cash Check Credit Card