WELCOME TO THE OFFICE OF
ROGIENSKI EYECARE
CHRISTINE ROGIENSKI, OD, PA

TODAY'S DATE _____/_____/_____

PATIENTS NAME: (FIRST)_____(LAST)_____

DATE OF BIRTH_____/_____/_____ AGE _____ MARITAL STATUS S M D W

EMAIL ADDRESS _____PHONE# _____-_____-_____ CELL HOME

STREET ADDRESS_____CITY_____STATE_____ZIP_____

OCCUPATION_____ EMPLOYED BY_____

SOCIAL SECURITY # LAST 4 -_____VISION INSURANCE_____ID#_____

PRIMARY INSURED NAME_____DATE OF BIRTH_____LAST 4 SSN_____

REFERRED BY_____HOBBIES_____

HOURS PER DAY SPENT ON COMPUTERS AND DIGITAL DEVICES_____

PLEASE CIRCLE OR LIST YOUR ANSWERS:

1) REASON FOR TODAY'S VISIT: ROUTINE EYE EXAM GLASSES CONTACT LENSES RED EYE(S) OTHER
   CHIEF COMPLAINT_____
2) PATIENT MEDICAL HISTORY: Diabetes, High Blood Pressure, Cancer, Blood Disorders, Current Pregnancy, Other

   _____
3) PATIENT MEDICATIONS/VITAMINS: (INCLUDE EYE DROPS. MEDICATIONS MAY AFFECT YOUR VISION):

   _____
4) FAMILY MEDICAL HISTORY: Diabetes, High Blood Pressure, Cancer, Blood disorders, Other

   _____
5) PATIENT/FAMILY OCCULAR HISTORY: BLINDNESS, CATARACTS, GLAUCOMA, LAZY EYE, MACULAR DEGENERATION, OTHER,

   WHO?_____
6) PATIENT ALLERGIES? THIS INCLUDES ENVIRONMENTAL AND/OR MEDICINAL ALLERGIES
   PLEASE LIST:_____
7) PATIENT EYE INJURY, EYE INFECTION HISTORY, OR EYE SURGERY? (WHEN?)_____

   PLEASE DESCRIBE:_____

DILATION: DILATION MAY BE NECESSARY FOR TODAY'S EXAM. DILATION MEANS THAT THE DOCTOR USES EYEDROPS TO ENARGE THE PUPIL AND CHECK RETINAL HEALTH INSIDE THE EYES. DILATING DROPS MAY CAUSE LIGHT SENSITIVITY AND A REDUCTION IN FOCUSING ABILITY FOR APPROXIMATELY 3 HOURS. HAVING A DRIVER IS RECOMMENDED. SUNGLASSES WILL BE PROVIDED.
PLEASE MAKE YOUR SELECTION BELOW:
( ) I CAN BE DILATED TODAY.
( ) I CANNOT BE DILATED TODAY, BUT I CAN SCHEDULE AN APPOINTMENT FOR DILATION AT A LATER TIME(AT NO CHARGE TO ME)
( ) I CHOOSE NOT TO BE DILATED.

HIPPA Compliance- A copy of our Notice of Privacy Practices can be viewed at http://www.takecareofyoureyes.com/privacy.pdf
Or will be provided at your request. Acknowledgement of Receipt
I acknowledge that I have been provided access to Rogienski Eyecare Notice of Privacy Policies

Signature_____ **Date**_____

WELCOME TO THE OFFICE OF
ROGIENSKI EYECARE
DR CHRISTINE ROGIENSKI OD, PA

OFFICE POLICIES:

*FEES FOR ALL VISITS TO THE OFFICE ARE DUE AND TO BE PAID AT THE TIME OF SERVICE.

*FEES PAID FOR EYE EXAMS, CONTACT LENS FITTING AND EVALUATION ARE NON-REFUNDABLE.

*EXAMINATIONS, INCLUDING CONTACT LENS FITTINGS INCLUDE 60 DAYS OF FOLLOW-UP. ADDITIONAL DOCTOR VISITS AFTER 60 DAYS WILL INCUR A $45 OFFICE VISIT FEE.

* IF CORRECT VISION INSURANCE (OR VISION DISCOUNT) INFORMATION IS NOT PRESENT BEFORE EXAMINATION, PATIENT MUST SELF-SUBMIT FOR REIMBURSEMENT AT OUT-OF-NETWORK RATE (OR MAY RESCHEDULE TO DAY WHEN CORRECT INSURANCE IS AVAILABLE).

*CONTACT LENS BOXES WHICH HAVE BEEN OPENED OR MARKED ON ARE NOT ELIGIBLE FOR RETURN OR EXCHANGE.

*EYEGLASSES HAVE A 60 DAY HAPPINESS Guarantee .

ALL FRAMES COME WITH A 1 YEAR MANUFACTURER'S WARRANTY. THE EXCHANGE WILL BE FOR THE SAME FRAME STYLE. IN THE EVENT THE SAME STYLE IS NO LONGER AVAILABLE, WE WILL WORK WITH YOU TO FIND A SIMILAR FRAME FROM THE SAME MANUFACTURER. FRAME VENDORS ARE NOT RESPONSIBLE FOR REPLACEMENT LENSES.

LENSES AND LENS COATINGS COME WITH A 1 YEAR MANUFACTURER'S GUARANTEE AGAINST SCRATCHING AND PEELING. COVERAGE DOES NOT APPLY TO DAMAGE OUTSIDE OF NORMAL WEAR AND TEAR.

THE OPTICIAN WILL EVALUATE TO DETERMINE WHETHER OR NOT A MANUFACTURER'S WARRANTY WILL APPLY.

SIGNATURE:_____DATE:_____