Modern Eyecare LLC.
100 North Water Street #2825
Norwalk, CT 06854
(203)-523-7204

PATIENT INFORMATION (Please print (black ink) clearly, thank you!)

Last Name_____ First Name_____ MI_____
Preferred Name_____ Preferred Pronouns_____
Birthdate_____/_____/_____
Address_____
City_____
State_____ Zip_____
Telephone Home (_____)_____
Cell(_____)_____
E-Mail_____
Occupation_____
Employer_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION
(If patient is under 18 years of age)
Last Name_____ First Name_____
Relation to Patient _____
Birthdate _____/_____/_____ Primary Phone (_____)_____

INSURANCE INFORMATION (If you have your cards, please give them to the front desk.)
Do you have vision insurance? No_____ Yes_____
Please list carrier_____
ID No._____
Group No._____
Do you have medical insurance? No_____ Yes_____
Please list carrier_____
ID No._____
Group No._____
Policy Holder: (if other than patient)
Last Name_____ First Name_____
Relation to Patient_____
Birthdate _____/_____/_____ Primary Phone (_____)_____

PATIENT HISTORY

How long has it been since your last eye exam?

_____

What is your primary reason for today's exam?

_____

Are you currently taking any medications? No_____ Yes_____
Please list all (If you have paper copy please give to the technician)

_____

_____

Are you allergic to any medication? No_____ Yes_____
Please list all (If you have paper copy please give to the technician)

_____

_____

Do you have any medical conditions/surgeries? No_____ Yes_____
If yes, please list all_____

_____

Do you smoke? (tobacco/cigarettes) Former_____ Current_____ Never_____ N/A_____
Do you drink? (alcohol) No_____ Yes_____ N/A_____
Are you currently pregnant? No_____ Yes_____ N/A_____
Have you ever had any eye disease, injury or surgery? No_____ Yes_____
Do you ever see double? No_____ Yes_____
Do you have frequent headaches? No_____ Yes_____
Do any of your blood relatives have diabetes? No_____ Yes_____
Do you or a blood relative have cataracts? No_____ Yes_____
Do you or a blood relative have glaucoma? No_____ Yes_____
Do you or a blood relative have macular degeneration? No_____ Yes_____
If yes to any of the above, please list who_____

CONTACT LENS INFORMATION

Are you interested in wearing contact lenses? No_____ Yes_____
Are you a new wearer to contact lens? No_____ Yes_____
Current brand of contact lens_____
Comfort issues? No_____ Yes_____ Dryness issues? No_____ Yes_____
Current prescription for contact lens_____

FINANCIAL POLICY

Full payment is due when services are rendered. Insurance must be presented, and member eligibility obtained on the date of service for insurance to be filed. We accept cash, all major credit cards, HSA/FSA, Apple/Google/Samsung Pay. Refunds will not be issued on services. Eyeglass and contact lens prescriptions are valid one year from the date of exam. By signing this form, you are giving us permission to submit an insurance claim on your behalf if Insurance information was provided.

INSURANCE CLAIMS

Modern Eyecare LLC. is a participating office with the Eyemed/Aetna/Anthem, Cigna, Connecticare, & Husky at this time. This means Modern Eyecare LLC, agrees to abide by the terms of those contracts. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for all services rendered. I understand that routine eye examinations may not be considered medically necessary by insurance plans, and I agree to be responsible for payment of such services. I hereby authorize Modern Eyecare LLC to deliver information to insurance carriers concerning my illness, if any, treatments, and assign to the doctor(s) all payments for medical services rendered to myself or dependents. I request that payment or any insurance benefits be made either to me on my behalf to Modern Eyecare LLC for any services provided to me by the doctor. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

MINOR PATIENTS (UNDER THE AGE OF 18)

The adult(s) accompanying a minor and/or the parent or guardian are responsible for the full payment. For unaccompanied minors, non-emergency treatment may be denied unless we have consent from the parent(s) or legal guardian.

CONTACT LENS PATIENTS

Refunds will not be issued on services that have been rendered. A contact lens evaluation does not guarantee any patient will be able to wear a contact lens successfully. If patients are new wearers to contacts, an insertion and removal training class must be successfully completed in order to dispense and finalize contact lens. Opened, damaged or marked contact lens boxes may not be returned or exchanged. Exchanges or returns must be made within 30 days of purchase date.

I have read, understood and agreed to all previous pages' information. I certify this information is correct to the best of my knowledge, I will notify you of any changes in my health status or the above information.

_____

Signature Print Date

RESPONSIBLE PARTY (GUARANTOR) INFORMATION
(If patient is under 18 years of age)

_____

Signature Print Date

_____Relation to Patient

Privacy Notice
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. Effective date 07/28/2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please scan the code below to access the Privacy Policy Form. Please read the form and then sign at the bottom of this page.

If you would like a paper copy, please ask the front desk. Thank you!

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Modern Eyecare LLC Notice of Privacy Practices.

Patient name_____

Signature _____

Date _____