

Welcome to For Your Eyes Only **Dr. R.A. Kriessler**
Dr. Scott Kriessler
Optometrists

5900 SOM Center Road
Willoughby, Ohio 44094
440-585-2020

Patient Information:

CONFIDENTIAL

Visit us online www.fyeo.net

Mr Mrs
Ms Miss
Name: _____ Birth Date: ____/____/____ Age: _____
Last First Middle Initial
Address: _____ Home Phone () _____
City, State, Zip _____ Work Phone () _____
Employer _____ Job Description _____
Emergency Contact/Number: _____ Relationship: _____
e mail: _____ How did you hear about our office: _____

Name of Vision Insurance _____ S.S. # _____

Name of Primary Care Physician: _____ Last Physical Exam: _____

Are you taking ANY Medications: (including oral contraceptives, aspirin, over the counter medication): **Please List**

Are you allergic to any Medications: Yes / No (list) _____

Circle any of the following you have had: Eye Surgery, Eye Injury, Eye Infections, Cataracts,
Glaucoma, Lazy Eye, Retinal Disease: Please Describe: _____

Any history of smoking, alcohol or substance abuse: _____

Do you have any problems in the following areas: Please Circle

- Neurological: (Headaches, Migraines, Seizures, TIA's)
- Ears, Nose, Mouth, Throat: (allergies, Hay Fever, Sinus Congestion, Chronic Cough, Dry Throat/Mouth)
- Respiratory: (Asthma, Chronic Bronchitis, Emphysema)
- Vascular/Cardiovascular: (Diabetes, Heart Pain, High Blood Pressure, Vascular Disease, High Cholesterol)
- Bones, Joints, Muscles: (Rheumatoid Arthritis, Muscle Pain, Joint Pain)
- Constitutional: (Fever, weight loss/gain)
- Integumentary: (Skin)
- Lymphatic / Hematologic: (Anemia, Bleeding Problems)
- Gastrointestinal: (Diarrhea, Constipation)
- Genitourinary: (Kidneys, Bladder)
- Allergic/Immunologic
- Endocrine: (Thyroid, other gland problems)
- Psychiatric: (Depression, Anxiety)
- Other: _____

Family History of Eye Disease: Glaucoma, Blindness, Macular Degeneration, Cataracts, Retinal Disease: None

Are you planning to get a Contact Lens Prescription today? Yes No
Involves fitting and evaluation of contact lenses, additional fee's apply

*Are you interested in finding out more about Laser Vision Correction Yes No
Over, Please

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*Would you like to learn more about Computer Vision Lenses? Yes Nc

*Would you like to learn more about Bifocal Contact Lenses? Yes Nc

*Hobbies: Please circle (we have many specialty eyewear options to enhance your vision)

Fishing Golf Boating Shooting Skiing Diving Flying Biking Swimming

Payment is expected when services are rendered: Your account will be paid by

Cash Check Credit Card Insurance

We must have all insurance information before today's examination. Many insurance companies require prior authorization. If we do not have all necessary information, you are responsible for payment, and we will file for your reimbursement.

Please Read Carefully:

I understand that my medical records are confidential, and by signing this consent form I am allowing my medical information to be released upon my insurance carrier's request, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment).

I also understand that I may revoke this consent by written request, at any time, with this doctor.

If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on our Patient Confidentiality Policy, please refer to the posted procedures, or ask for a brochure on how we protect your health information. We update the Patient Confidentiality Policy periodically, and reserve the right to make changes as required. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restrictions in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment in full for all services rendered on my behalf, or on the behalf of my dependents. I authorize and request my insurance company to pay my eye doctor directly.

The fees for examination are good for 30 days after the initial exam. Questions with glasses or contact lens prescriptions must be addressed within this time or additional fees will be incurred. After 30 days, you will be charged a fee per visit to solve any prescription questions. All materials must be picked up within 60 days of notification that materials are completed or you will forfeit your deposit. Any outstanding balances are subject to an interest charge of 2% per month. Returned checks are subject to a \$40 fee, and if a collection agency has to be used to recover the original check amount, the fee is \$80.

I declare that I have read and understand the above information and have answered the questions accurately. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient (or parent if minor) _____

Date

If Minor, Responsible party:

Name: _____

Address: _____

City, State, Zip: _____

Phone: () _____

SS# _____