Welcome to
For Your Eyes Only

Dr. Robert Kriessler
Dr. Scott Kriessler
Dr. Michelle Lieb
Optometrists

5900 SOM Center Road
Willoughby, OH 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: ______________________________ Cell Phone: ( ) ________

Emergency Contact/ Number: ______________________________ Relationship: ________

E-mail: ______________________________ Whom may we thank for referring you: ________

Name of Insurance: ______________________________ Policy Holder Name/ S.S. #: ________

Name of Primary Care Physician: ______________________________ Last Physical Exam: ________

Preferred Language: ____________ **Race:** ____________ Ethnicity: ☐ Hispanic ☐ Non Hispanic

Do you have, or have you ever had any problems in the following areas: (check all that apply)

Constitutional: ☐ Developmental Disabilities ☐ Cancer ☐ Fatigue Syndrome
Ears, Nose, Mouth, Throat: ☐ Hearing Loss ☐ Sinusitis ☐ Dry Throat/Mouth ☐ Laryngitis
Neurological: ☐ MS ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Migraines ☐ Stroke/CVA
Psychiatric: ☐ Depression ☐ Attention Deficit ☐ Anxiety Bipolar Disorder
Cardiovascular: ☐ Hypertension ☐ Stroke/CVA ☐ Heart Attack ☐ Vascular Disease ☐ Congestive Heart Failure
Respiratory: ☐ Smoker ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Chronic Obstruction ☐ Sleep Apnea
Gastrointestinal: ☐ Crohn’s ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease
Genitourinary: ☐ Kidneys ☐ Prostate ☐ STD-Herpetic ☐ Chlamydia ☐ Pregnant ☐ Nursing
Muscles/ Skeletal: ☐ Arthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Gout
Integumentary: ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Herpes Skin Lesions
Endocrine: ☐ Diabetes Type I ☐ Type II ☐ Thyroid ☐ Horomone Dysfunctions
Lymphatic/ Hematologic: ☐ Anemia ☐ History of Large Blood Loss ☐ Cholesterol
Allergic/ Immunologic: ☐ Allergies ☐ RA ☐ Lupus ☐ Sjogren’s Syndrome
Other: ______________________________

Please list current medications: ______________________________

____

____

Current Height: ______________________________ Current Weight: ______________________________

Are you allergic to any Medications? ☐ Yes ☐ No (list): ______________________________

Check any of the following you have had: ☐ Crossed Eyes ☐ Lazy Eyes ☐ Drooping Eyelid ☐ Glaucoma ☐ Retinal Disease ☐ Cataracts ☐ Eye Infections ☐ Injury ☐ Eye Surgery (type): ______________________________

Smoking? ☐ Yes ☐ No ☐ Former

Alcohol use: ☐ Yes ☐ No

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

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Are you planning to get new eyeglasses today?: ☐ Yes ☐ No ☐ Only if RX Changes

Are Contact Lenses part of your examination today?: ☐ Yes ☐ No ☐ Only if RX Changes
Involves fitting and evaluation of contact lenses, additional fee's apply, depending on lens Type

Are you interested in finding out more about Laser Vision Correction?: ☐ Yes ☐ No

Hobbies: Please check (we have many specialty eyeware 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 todays 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 medicalinformation to be released upon VSP (or another insurance carrier) 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. If revoked, all fee for service will be private pay going forward.

For additional information on our Patient Confidentiality Policy, please refer to our web site at www.fyeo.net. 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 restriction 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 eye care 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.

Advanced Beneficiary Notice; The OptoMap Retinal Exam may not be covered by your insurance carrier. If reviewed with you by the doctor, there is a fee for this test of $39. If you elect, there is a charge of $15 for the MPOD.

The fees for examination are good for 30 days after the initial exam. Problems 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 problems. All materials must be picked up within 60 days 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) ______________________________

Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________