WELCOME

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

NAME: ____ Social Security: ____________________
Last name First name Middle

ADDRESS: ____

CITY, STATE ____ ZIP CODE: _______________________

HOME PHONE: __________________ WORK PHONE: _________________ CELL: _________________

❒ MALE ❒ FEMALE AGE ____________ DATE OF BIRTH ________________________________

❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED ❒ DEPENDENT CHILD

PATIENT'S EMPLOYER: ____

BUSINESS ADDRESS: ____

WHO REFERRED YOU TO THIS OFFICE? ____

ANY FRIENDS / RELATIVES WHO ARE PATIENTS HERE? _____________________________________

WHO IS YOUR PRIMARY CARE DOCTOR? ____

ADDRESS: __________________________ TELEPHONE _________________ FAX: ________________

IF YOU GO TO A CLINIC, WHAT IS THE NAME OF THE CLINIC? ______________________________

IF YOU DO NOT SPEAK ENGLISH, NAME / PHONE NUMBER OF PERSON WHO DOES:

____

TYPE OF INSURANCE: ____

CARDHOLDER NAME: ____

CARDHOLDER DATE OF BIRTH: __________________ SOCIAL SECURITY #: _____________________

IS THE PATIENT A DEPENDENT CHILD? ❒ YES ❒ NO

IF YES, PARENT OR GUARDIAN NAME: ____

WORK PHONE NUMBER: ____

I AUTHORIZE MY INSURANCE COMPANY TO PAY MEDICAL BENEFITS DIRECTLY TO NEERU DUA, MD.

____
Patient Signature Date

MEDICAL HISTORY FORM

DATE ______ PATIENT NAME ______ DATE OF BIRTH ______

LIST ANY FOOD / DRUG / LATEX ALLERGIES:

______

LIST THE NAMES OF PRESCRIPTION MEDICATIONS YOU TAKE:

______

ARE YOU BEING TREATED FOR DIABETES? ❒ YES ❒ NO If yes, for how many years? ______

ARE YOU PRESENTLY TREATED FOR ANY OF THE FOLLOIWNG DISEASES?

ANEMIA	❒ YES	❒ NO	HIGH BLOOD PRESSURE	❒ YES	❒ NO
ASTHMA	❒ YES	❒ NO	HEART DISEASE	❒ YES	❒ NO
CANCER	❒ YES	❒ NO	KIDNEY DISEASE	❒ YES	❒ NO
ULCERS	❒ YES	❒ NO	THYROID DISEASE	❒ YES	❒ NO
AIDS / HIV	❒ YES	❒ NO	LIVER DISEASE	❒ YES	❒ NO
STROKE	❒ YES	❒ NO	BLOOD DISORDER	❒ YES	❒ NO
ARTHRITIS	❒ YES	❒ NO	HIGH CHOLESTEROL	❒ YES	❒ NO
RHEUMATOID ARTHRITIS	❒ YES	❒ NO	MS (Multiple Sclerosis)	❒ YES	❒ NO
DEPRESSION	❒ YES	❒ NO	OTHER [Describe]	❒ YES	❒ NO

OTHER CONDITIONS: ______

Have you ever been hospitalized or had major surgery? ❒ YES ❒ NO

IF YES, EXPLAIN: ______

REVIEW OF SYSTEMS: Do you CURRENTLY have any of the following problems:

- Chronic fever, weight loss / gain, fatigue ❒ YES ❒ NO
- Ear / Nose / Throat problems [i.e. hearing loss; sinus] ❒ YES ❒ NO
- Heart Problems [chest pain; irregular heart beat] ❒ YES ❒ NO
- Respiratory problems [shortness of breath, emphysema] ❒ YES ❒ NO
- Gastrointestinal problems [heartburn, pain, diarrhea] ❒ YES ❒ NO
- Urinary problems [pain, blood in urine, kidney stones] ❒ YES ❒ NO
- Skin problems [rashes, eczema, psoriasis, cancer] ❒ YES ❒ NO
- Musculoskeletal problems [joint pains, weakness] ❒ YES ❒ NO
- Neurological Problems [numbness, weakness, headaches] ❒ YES ❒ NO
- Psychiatric problems [depression, anxiety, ADD] ❒ YES ❒ NO

IS THERE A FAMILY HISTORY OF **IF YES WHO:**

DIABETES	❒ YES	❒ NO	___
GLAUCOMA	❒ YES	❒ NO	___
MACULAR DEGENERATION	❒ YES	❒ NO	___

DO YOU SMOKE? ❒ YES ❒ NO IF YES, HOW MUCH? ___

DO YOU DRINK ALCOHOL? ❒ YES ❒ NO HOW MUCH? ___

EYE HISTORY

HAVE YOU EVER BEEN TOLD YOU HAVE ANY OF THE FOLLOWING EYE DISEASES?

GLAUCOMA	❒ YES	❒ NO	MACULAR DEGENERATION	❒ YES	❒ NO
“LAZY” EYE	❒ YES	❒ NO	DIABETIC RETINOPATHY	❒ YES	❒ NO
CATARACTS	❒ YES	❒ NO	RETINAL DETACHMENT	❒ YES	❒ NO
DRY EYES	❒ YES	❒ NO	OPTIC NEURITIS	❒ YES	❒ NO

HAVE YOU EVER HAD ANY EYE SURGERY OR LASER PROCEDURE(S): ❒ YES ❒ NO

DESCRIBE: ___

DO YOU REGULARLY TAKE ANY EYE DROPS? ❒ YES ❒ NO

IF YES, WHAT ARE THEY: ___

DO YOU CURRENTLY HAVE ANY OF THESE EYE SYMPTOMS?

GRITTY FEELING	❒ YES	❒ NO	SENSITIVITY TO SUNLIGHT	❒ YES	❒ NO
WATERY EYES	❒ YES	❒ NO	SENSITIVITY TO HEADLIGHTS	❒ YES	❒ NO
ITCHING	❒ YES	❒ NO	RECENT VISION LOSS	❒ YES	❒ NO
BURNING	❒ YES	❒ NO	EYE PAIN	❒ YES	❒ NO

DO YOU WEAR GLASSES AND / OR CONTACTS? ❒ YES ❒ NO

___

PATIENT SIGNATURE DATE

Acknowledgement of Receipt of Notice

Armory Eyecare
Neeru Dua, M.D.
Bradford Newman, O.D.
836 Farmington Avenue, Suite 121
West Hartford, CT 06119
PHONE: (860) 233-9671 | FAX: (860) 236-3607

Name of Patient: ____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ____ Date: ________________________

Print Name: ____________________________________ Telephone: ____________________

If not signed by the patient, please indicate your relationship to the patient:

____

By signing this paper, you are giving our office permission to:

- Contact you by phone
- Correspond with you by mail and / or FAX
- Call in prescriptions to your pharmacy
- Speak to other physicians about your case
- Speak to family members about you when necessary

If you have any objections, please let us know.

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Dear Patient:

The practice of Neeru Dua, M.D. participates in most insurance plans. What this participation means is that the office will submit all claims to the insurance(s) you provide to us, and they will pay us directly for COVERED-SERVICES.

This DOES NOT mean that you will have no financial responsibility to Dr. Dua.

YOU ARE RESPONSIBLE FOR:

- **DEDUCTIBLES** – If your insurance company has any [Medicare is $166 / year].
    - If you have met your deductible — you may be responsible for the entire bill.
- **CO-PAYS** – if your insurance company asks for this, it MUST BE PAID AT THE TIME OF THE VISIT or the visit may need to be rescheduled.
- **REFRACTION FEE** – some insurances cover a REFRACTION, while others do not. You will be responsible for the $50.00 fee if your insurance doesn't.
- **REFERRAL FORMS** – some insurance require you to get a REFERRAL from your PCP [Primary Care Provider] PRIOR TO OYUR VISIT.
- **PROVIDING THE CORRECT / UPDATED INSURANCE** – You are responsible to provide us with your updated insurance. If we do not have your correct insurance information, you will be responsible for the entire bill. You will be billed if the claim is unpaid; after 90 DAYS the bill will be sent to Collection if unpaid.
- **KNOWING IF INSURANCE HAS A SEPARATE VISION RIDER** – Some plans do not pay for Routine eye exams. Some need a Prior Authorization and some plans we do not participate in.

There are additional fees for contact lenses [checkups; fittings]. In order for us to submit all your claims, we need you to sign the following statement and provide WITH ALL OF YOUR ACCURATE INSURANCE information. This includes your PRIMARY insurance and your SECONDARY insurance(s) as well.

BENEFICIARY SIGNATURE REQUIREMENTS

"I request that payment of any authorized benefits be made on my behalf to Dr. Neeru Dua, M.D. for any services furnished to me by Dr. Dua or other doctors in her office. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information to determine these benefits or benefits payable for related services.

____

Patient Signature Date