



GREAT BRIDGE EYE CARE

Lindsey M. Vernillo, O.D.
Mary Chandler, O.D.
William C. Holcomb, O.D., F.A.A.O.
160 Mt. Pleasant Road Chesapeake, VA 23322
757-482-4022

ACKNOWLEDGEMENT OF RECEIPT

Patient Printed Name _____

Patient/Parent Signature _____

Date: _____

PATIENT PAYMENT AGREEMENT

I request that payment of authorized insurance benefits for any service furnished me be made on my behalf to the office of Great Bridge Eye Care, Lindsey M. Vernillo, O.D. I authorize any holder of medical information about me to release the information needed to determine the benefits payable for related services. I accept responsibility for any unpaid claims that are denied because a correct referral was not provided. In the event that my insurance should not pay for the products or services provided, I agree to be responsible for payment to Great Bridge Eye Care, Lindsey M. Vernillo, O.D. I understand that professional fees, insurance deductibles and co-payments are due at the time of the visit.

Contact lens wearers: In most cases contact lens are not considered "medically necessary" by some insurance plans. Any tests performed to update a contact lens prescription or to refit you with a new lens may not be covered under your plan and will be the responsibility of the patient.

Patient Signature _____

Date _____

PATIENT INFORMATION

Date _____

Last Name _____ First _____ MI _____

DOB _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Daytime _____ Cell _____ Email _____

Employer _____

PARENT/GUARDIAN INFORMATION

Last Name _____ First _____ MI _____

DOB _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Work _____ Cell _____ Email _____

Employer _____

How did you hear about our office? _____

VISION INSURANCE

Plan Name _____ ID #/SSN _____

Policy Holder Name _____

MEDICAL INSURANCE

Plan Name _____ ID #/SSN _____

Policy Holder Name _____ DOB _____

Secondary _____

Primary Care Physician _____

Address _____

Phone Number _____ Fax Number _____

SOCIAL HISTORY

Do you use tobacco products? YES NO

If you circled yes, what type of tobacco? _____

For how long? _____

Amount of pack(s)/day? _____

Do you drink alcohol? YES NO

If yes, how much/often? _____

Do you use illegal drugs? _____

If yes, type/amount/how long? _____

Please circle if you have been exposed to the following below:

Gonorrhea Hepatitis HIV Syphilis

Are you pregnant and/or nursing? YES NO

Do you currently wear glasses? YES NO

How old is your current pair? _____

Do you currently wear contact lenses? YES NO

Are you interested in contact lenses? YES NO

MEDICAL HISTORY

Please list all medical conditions: _____

Please list all medications and dosages below.

Medication	Dosage

Medication	Dosage

Are you allergic to any medications? YES NO
 If yes, please list the medication and the reaction you had below:

Have you had any ocular surgeries? YES NO
 If yes, please explain _____

Have you ever been hospitalized, had any surgeries, or broken bones? YES NO
 If yes, please explain _____

FAMILY HISTORY

Please list any family member (maternal/paternal grandparents, parents, siblings, and/or children) living or deceased that have the following conditions

- | | |
|----------------------------|---------------------------|
| Blindness _____ | Arthritis _____ |
| Cataract _____ | Cancer _____ |
| Eye turn _____ | Diabetes _____ |
| Glaucoma _____ | Heart Disease _____ |
| Macular Degeneration _____ | High Blood Pressure _____ |
| Retinal Disease _____ | Kidney Disease _____ |
| Retinal Detachment _____ | Thyroid Disease _____ |
| | High Cholesterol _____ |

Patient Payment Agreement

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Patient Signature: _____ Date: _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fever, Weight loss/gain YES NO

INTEGUMENTARY (SKIN) YES NO

NEUROLOGICAL

Headaches YES NO

Migraines YES NO

Seizures YES NO

Fainting YES NO

Numbness/Tingling YES NO

Autism Spectrum Disorder YES NO

EYES

Loss of vision YES NO

Blurry vision YES NO

Distorted vision YES NO

Double vision YES NO

Dry eyes YES NO

Discharge YES NO

Redness YES NO

Sandy, gritty feeling YES NO

Itching YES NO

Burning YES NO

Foreign body sensation YES NO

Excess tearing YES NO

Glare/light sensitivity YES NO

Eye pain/soreness YES NO

Chronic infection YES NO

Sties YES NO

Flashes/floaters YES NO

ENDOCRINE

Thyroid disease YES NO

Diabetes YES NO

Heat/cold intolerance YES NO

PSYCHIATRIC

ADD/ADHD YES NO

Depression YES NO

Nervous YES NO

Stress YES NO

Memory loss YES NO

EARS, NOSE, MOUTH,

Allergies/Hay fever YES NO

Sinus problems YES NO

Runny nose YES NO

Chronic cough YES NO

Dry throat/mouth YES NO

RESPIRATORY

Asthma YES NO

Chronic Bronchitis YES NO

Emphysema YES NO

Sleep Apnea YES NO

Shortness of breath YES NO

Wheezing YES NO

VASCULAR

Chest pain YES NO

High blood pressure YES NO

Elevated cholesterol YES NO

Other vascular disease YES NO

Chest tightness YES NO

GASTROINTESTINAL

Diarrhea YES NO

Constipation YES NO

Nausea YES NO

IBS YES NO

GENITOURINARY

Kidney/bladder problems YES NO

Genital problems YES NO

BONES/JOINTS/MUSCLES

Rheumatoid arthritis YES NO

Osteoarthritis YES NO

Muscle/joint pain YES NO

LYMPHATIC/HEMATOLOGIC

Anemia YES NO

Bleeding problems YES NO

Cancer YES NO

Lupus YES NO

Circle any of the following that YOU have/had:

Lazy eye

Glaucoma

Retinal Disease

Cataracts

Eye injuries

Eye infections

Droopy Eyelids

Prominent Eyes