PITTSBURGH EYE ASSOCIATES

Roxana F. Barad, M.D.
Eye M.D. & Surgeon

4424 Penn Avenue, Ste. 101
Pittsburgh, PA 15224
Phone (412) 683-0500
Fax (412) 683-1943

Christopher Cecchini, O.D.
Jerome Mattes, O.D.
Optometrists

3414 Main Street
Munhall, PA 15120
Phone (412) 461-2112
Fax (412) 461-4239

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to meeting all of your eye care needs.

Patient Information

Name: _____ SS#: _____ Sex: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work: _____ Other: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ PCP Phone: _____

Who referred you or how did you hear about us (website, patient, facebook, etc? _____

What type of insurance do you have? _____

Are you the policy holder? Yes No (If no, please answer next question, if yes, leave blank)

- Parent Name: _____ SS#: _____ DOB: _____
- Spouse Name: _____ SS#: _____ DOB: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Home Phone _____

Work Phone: _____ Date of last eye exam: _____

Do you wear: **Glasses:** How Often? _____ **Contacts:** What Type? _____ How Often? _____

- Right Eye Prescription: _____ Left Eye Prescription: _____

Please Read and Sign Below:

I hereby authorize the release of information acquired during the course of my examination and treatment to the Health Care Financing Administration or any other third party carrier as necessary to secure payment of any benefits due to me. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until cancelled in writing or replaced by one of later date. A photocopy of this assignment shall be considered as valid as the original. I have read and understand the above information.

_____

Patient Signature Date

_____

Parent/Guardian Date

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Patient Health History

Reason for today's visit: _____

Eye Complaints:
☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge ☐ Dryness ☐ Blurred Vision
☐ Glare from Lights/Halos ☐ Poor Night Vision ☐ Poor Color Vision ☐ Flashes of Light
☐ Spots/Floaters ☐ Double Vision ☐ Light Sensitivity

Current/Past Health History:
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Crossed Eyes
☐ Lazy Eye ☐ Headaches/Migraines ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Condition
_____ ☐ Diabetes _____ ☐ Asthma/COPD ☐ Epilepsy ☐ Kidney Disease
☐ Thyroid Disease ☐ Lupus ☐ Arthritis ☐ Stroke ☐ Cancer ☐ AIDS/HIV ☐ Hepatitis
☐ Chemical Dependency ☐ Tuberculosis ☐ Rheumatic Fever ☐ Skin Conditions _____
☐ Bleeding Problems

Are you pregnant? _____
Do you currently or formally use tobacco? Yes No Stop Date: _____
Do you use alcohol? Yes No ☐ Daily ☐ Social

List of Medications: ☐ **NONE**

_____
_____
_____
_____

List of Allergies: ☐ **NKDA**

_____
_____
_____

List of Surgeries: ☐ **NONE**

_____
_____
_____

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HIPAA FORM
Acknowledgement of Receipt of Notice

I acknowledge that I have been offered the Pittsburgh Eye Associates "Notice of Privacy Practices"

- ◉ I would like a copy
- ○ I would not like a copy

Person(s) you authorize to receive your medical information / or whom we may contact in case of an emergency:

Name: _____ Relationship: _____ Phone: _____
☐ Emergency contact

Name: _____ Relationship: _____ Phone: _____
☐ Emergency contact

Name: _____ Relationship: _____ Phone: _____
☐ Emergency contact

Name: _____ Relationship: _____ Phone: _____
☐ Emergency contact

Patient Name: _____ Signature: _____

Witness: _____ Date: _____

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TO: ALL PATIENTS USING INSURANCE PLEASE READ CAREFULLY

As Pittsburgh Eye Associates is a medical eye care practice, all patients will be asked to provide their medical insurance cards. **Your medical carrier will be billed for treatment of eye disease, detection of eye and visual system disorders, and dilated ophthalmic examinations.** If your medical carrier requires a co-pay, it must be paid on the day of your visit.

Vision insurances (Davis, EyeMed, NVA, Opticare, Spectera, VBA, VSP, and UPMC Vision Advantage) cover refraction (measurement of spectacle prescription) and routine examinations. These plans may also require a co-pay, depending on your carrier.

Patients having both a refraction (vision exam) and medical eye exam must pay both co-pays, when applicable.

Patients are financially responsible for procedures and testing that is not covered by their insurance.

If you have any questions, please ask our staff, they will answer any insurance questions you may have.

Please sign and date the form below to confirm that you have read and understand Pittsburgh Eye Associates insurance policy.

_____ _____

Patient Signature (or Guardian) Date

_____

Print Patient Name