

Guardian: _____ Date: 8/1/09
Name: _____
Address: _____
City, St: _____ Zip: _____
Phone(H): _____ (W): _____
Phone (C): _____ SS# _____
E-Mail: _____

Date of Birth: _____ Sex: _____

Vision or Primary Insurance
Ins.: _____ #: _____
Insured: _____ DOB: _____
Relationship: _____

Medical or Secondary Insurance
Ins.: _____ #: _____
Insured: _____ DOB: _____
Relationship: _____

Contact me by: [] Email [] Work phone [] Mail
[] Home phone [] Cell phone

Referred by (please write name so we can thank)
Referral's name _____
[] Friend [] Spouse/partner [] Yelp
[] Insurance [] Website [] Other...

Medical Doctor(s): _____

How long since last eye exam: _____

Allergies Current Medicines (please list)

- [] None
[] Codeine
[] CL solutior
[] Eye drops
[] Novocain
[] Penicillin
[] Sulfa
[] Other...

Please initial each as indicated . . .
I WOULD like a copy of "Hipaa Policies"
I would NOT like a copy of "Hipaa Policies":
I have read and understood "Office Policies"
I have read and understood "Note to Contact Lens Wearers"

Signature _____ Date _____

Personal Medical History (do you have or have you ever had?..)

- [] Allergies [] Fever, recent [] Migraine
[] Arthritis [] Gastrointest. cond. [] MS
[] Anxiety/depression [] Glaucoma [] preg./nursing (now)
[] Asthma [] Heart disease [] Skin cond.
[] Cancer [] High blood press. [] Thyroid cond.
[] Cataract [] High cholesterol [] Other...
[] COPD/emphysema [] HIV
[] Diabetes [] Keratoconus
[] Droopy eye lid [] Kidney disease
[] Eye infections [] LASIK / PRK
[] Eye injuries [] Lazy eye
[] Eye surgery [] Macular Degen.

Eye Wear History (have you ever worn?..)

- [] Glasses [] OTC readers [] Astig. contacts [] Other...
[] Bi-/Tri-focals [] Soft contacts [] Bifoc. contacts
[] No line bifocals [] Gas perm./hard [] Overnight wear

Family History (parents, grandparents, siblings, children)

- [] Blindness [] Heart disease [] Retinal disease
[] Cataracts [] High blood press. [] Thyroid cond.
[] Cancer [] Kidney disease [] None
[] Color blind [] Lazy eye [] Other...
[] Diabetes [] Macular degen.
[] Glaucoma [] Retinal detach.

Social History

- [] Bike/motorcycle [] Music [] Tennis
[] Computer [] Reading [] Video games
[] Crossword/puzzles [] Running [] Other...
[] Exercise [] Scuba/swim
[] Fishing/boating [] Sewing etc.
[] Golf [] Skiing

Occupation

Current eye problem(s) (please check all, circle the "main" problem)

- [] Blur at distance [] Floating spots [] Diff. with contacts, vision
[] Blur at near [] Dizziness [] Diff. with contacts, comf.
[] Dryness [] Double vision [] Lost glasses
[] Burning [] Sandy/Gritty Feeling [] Ran out of contacts
[] Itching [] Sensitivity to light [] Other...
[] Tearing [] Frequent head aches
[] Eye pain [] Annual check up
[] Eye strain [] Diabetes eye check
[] Redness [] Medical eye check
[] Discharge/mucus [] Diff. with glasses, vision
[] Flashing lights [] Diff. with glasses, comf.

[] Right eye [] Left eye [] Both eyes

[] Mild [] Moderate [] Severe

[] Started today [] 3-7 days [] 2-4 weeks [] 3-6 months
[] 1-2 days [] 1-2 weeks [] 1-3 months [] Over 6 months

[] Getting better [] Worse AM [] No change
[] Getting worse [] Worse PM

Are you interested in contact lenses? No / Yes
Are you interested in refractive surgery (lasik)? No / Yes

For office use only

Glasses R-
L-

Contacts R-
L-



LOCATIONS

Andersonville

5222 N Clark St
Chicago, IL 60640
[T] 773.275.2538
[F] 773.275.0344

Loop

181 W Madison Ave
Suite 125
Chicago, IL 60602
[T] 312.201.8989
[F] 312.201.8984

[W] visionaryec.com

DOCTORS

M. Ciszek, OD
J. Warner, OD
S. Guzik, OD

OFFICE CONTACT

Michael Ciszek, OD
michael@visionaryec.com

OFFICE POLICY

Please respect our office policies. These policies are in place to make everyone's experience more pleasant.

PLEASE:

- **give us at least 24 hours notice before canceling any appointment (exam or follow-up).**
Patients giving us less than 24 hours notice will be charged a \$25 fee.
- **arrive on time.**
Patients arriving more than 10 minutes late will be asked to reschedule. This is only fair to the patients scheduled after you. Our doctors respect your time and try to balance the needs of each patient while staying on schedule.
- **discuss insurance coverage issues with your company's human resource personnel.**
We are required to abide by each company's rules and are not allowed to modify coverage, effective dates, etc. unless authorized to do so by your insurance company.
- **understand that you are ultimately responsible for your bill.**
You will be billed for any services or materials that your insurance company fails to cover.
- **understand that we custom order your glasses and contact lenses.**
Any orders cancelled on the same day will be charged a 10% restocking fee. Refunds will be issued in the same form as the original payment. Orders cancelled the next day or later will be charged a 10% restocking fee and issued a store credit only.
- **limit cell phone use to emergency use only.**

REFERRAL PROGRAM

Please take advantage of our referral program.

We give you a \$25.00 office credit for each new patient that you refer.

NOTE TO CONTACT LENS WEARERS

A contact lens is a medical device and like other medication requires a doctor for any changes. Your prescription includes brand name, base curve, diameter, lens strength, number of refills allowed, and an expiration date (maximum one year).

An annual eye examination by your doctor is required to renew or change a prescription. Per industry and insurance standards, your contact lens evaluation has a separate diagnostic fee.

This fee is in addition to your general eye examination.

No retailer, optician or online service is allowed to dispense contact lenses beyond the prescribed refills, beyond the expiration date or to change the defining parameters of a prescription.

This policy is regulated by the Federal government.



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OFFICE CONTACT

Michael Ciszek, OD
michael@visionaryec.com

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and understood Visionary Eye Care Professionals, PC
"Notice of Privacy Practices."

- I do wish to receive a copy of Visionary Eye Care Professionals, PC
"Notice of Privacy Practices."
- I do not wish to receive a copy of Visionary Eye Care Professionals, PC
"Notice of Privacy Practices."

PRINT PATIENT NAME

PATIENT SIGNATURE

DATE

Thanks for filling out Patient Information ahead of your appointment!

Please print this before your visit to receive:

\$10.00 OFF
YOUR INSURANCE COPAY



ANDERSONVILLE | LOOP