

Westchester Health Associates Ophthalmology Division

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Dear New Patient:

Welcome to the Ophthalmology Division of Westchester Health Associates. Thank you for selecting us to provide your family medical eye care. Your comprehensive ophthalmic examination will take approximately 60 minutes. To ensure things run as smoothly as possible, here are just a few reminders:

Referrals:

Some insurance policies require a referral from your primary care doctor before you can be examined by a specialist. This is true even for emergency visits. If your plan requires a referral, please call your primary care physician at least a few days before your exam to obtain your referral. Then call our office the day before your appointment to make sure it has arrived. If a referral is required but has not arrived in our office, we may be unable to see you.

Insurance Card:

It is extremely important that you have **your most up to date** insurance card with you at the time of your examination. If we are unable to verify active insurance coverage, we will be unable to see you. And since you are a new patient to our division, it would be helpful for you to bring a form of photo identification with you as well.

Reminders for your up-coming examination:

Please remember to bring:

For contact lens wearers: Please **wear the contact lenses** when you come in for your eye exam and bring your eyeglasses with you. However, if you are having a problem with your contact lenses, please wear your glasses, but bring your contact lenses with you. Also, please bring either the boxes/packages the contacts came in or your current contact lens prescription.

For all patients: Please bring any eyeglasses you are **currently** using, even if they are an older prescription.

Also, please fill out the attached medical history form completely **(both pages)** ahead of time **and bring it with you to your appointment.**

If you need to cancel or reschedule you appointment, please call our office one business day prior in order for us to fully utilize our schedule and be able to accommodate any emergency patients that may need to be seen. Thank you again for selecting us to be your ophthalmologists.

Westchester Health Associates: Services our Practice Offers to Our Patients:

Services covered by most medical insurance: Medical insurance companies require a medical diagnosis in order to cover an ophthalmic examination. These services must be considered medically necessary by your particular insurance company. Different companies have different criteria for what they consider medically necessary. It is in the patient's best interest to contact your insurance carrier if you have questions about your particular coverage.

Services NOT covered by medical insurance: These are services not covered by most medical insurance plans because they are considered vision related and not medical. However, some medical insurance plans which also have vision coverage may cover some of these services. Please call your insurance carrier to see what your plan may cover. Examples of these services are:

Routine Eye Checkup: This is a comprehensive eye examination where there is no specific eye complaint and there is no medical eye diagnosis or problem. However, certain insurance companies will cover well eye exams for children under 18. (Please check with your insurance carrier for details on your plan.)

Contact Lens fitting: Determining the correct power, shape, curvature, oxygen transmissibility, adaptation and wear schedule best suited for the particular eye. This involves patient training **and follow up exams** to ensure corneal health and adherence to the details of correct contact lens wear. We are able to offer contact lens fittings for near and farsightedness, astigmatism, presbyopia (reading difficulty), and for corneal disease (i.e. Keratoconus)

Refraction (\$55 Charge): This is how we determine the type of spectacle correction needed to improve your vision, or modification of your present spectacle prescription. This involves measuring near sightedness, farsightedness, and astigmatism. This procedure is called a **REFRACTION** and **is not covered** by most medical insurance plans. If you have a vision plan in addition to your medical insurance, they may cover this charge. ***The only vision plan that we participate with is VSP.*** If you have VSP, it is important that you inform us when you come in for your appointment so we can obtain an authorization for your exam that day. If you have a vision plan other than VSP you will need to submit a form to your plan to obtain coverage for this service and then they will reimburse you directly.

Annual Contact Lens Evaluation (\$30 Charge): This is the examination of the contact lenses to determine their health impact on the cornea (swelling, blood vessel growth, etc.) , need for power changes, need for change in fitting characteristics or lens type based on shape changes of the eye, wear schedule changes, oxygen transmissibility needs, and other factors affecting the health of the eye.

MEDICAL HISTORY And REVIEW Of SYSTEMS FORM

Name: _____ **Date:** _____

Home Address: _____ Home Phone: _____
 City, State, Zip: _____ Date of Birth: _____ Primary Doctor _____
 Employer _____ Party Responsible for Payment: _____
 (if other than self)
 Business Address: _____ Address _____

 Business Telephone: _____ City, State, Zip _____

 Telephone _____
 Relationship to Patient: _____

No Yes

Do you have a **Vision Care Plan** such as VSP ? If "YES" which one ? _____

PAST MEDICAL HISTORY

Are you allergic to any medications ? No Yes List here: _____

List all medications you are taking, including vitamins, supplements, and OTC: _____

List all major illnesses and injuries: _____

List any surgeries you have had: _____

Do you currently have any problems in the following areas ?

EYES	Yes No		Yes No		Yes No			
	Yes	No	Yes	No	Yes	No		
Loss of Vision			Seeing Halos			Flashing lights a/o floaters		
Blurred Vision			Dryness			Foreign Body Sensation		
Fluctuating Vision			Tearing or Watering			Trouble with Night Vision		
Distorted Vision			Discharge / Crusting			Pain or Soreness		
Glare or Light Sensitivity			Redness			Infection of Eye or Lid		
Loss of Side Vision			Sandy or Gritty Feeling			Tired Eyes		
Double Vision			Itching a/o burning			Drooping Eyelid		

For the following areas, if "Yes" please provide additional information:

	Yes	No
GENERAL / CONSTITUTIONAL (fever, weight loss, other)		
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, other)		
CARDIOVASCULAR (high BP, racing pulse, irregular heartbeat, etc.)		
RESPIRATORY (congestion, wheezing, cough, etc.)		
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)		

Details

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If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid problems, etc.)			
BLOOD / LYMPH (high cholesterol, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY			
Do you have a family history of ?	YES	NO	Relationship
Blindness or Macular Degeneration			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Migraine headaches / Other			

SOCIAL HISTORY

Occupation (If retired, please list former occupation) _____ Race _____

Marital status _____ Do you live alone, or with other adult(s)

Yes No

Do you drive ?

Do you spend a lot of time outdoors ? If yes, do you customarily wear sunglasses ? Yes No

Do you wear contact lenses ?

Do you have a history of drug abuse ?

Do you drink alcohol ? If "Yes" circle: occasionally 1/day 2-3/day 4+/day

Do you smoke ? If "Yes" circle: 1/2 pack/day 1 pack/day 1+ pack/day

Patient's Signature: _____

Print Name: _____