MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

CHAUNHI VAN, M.D.
Ophthalmologist

KYLE CALLAWAY, O.D.
Board Certified Optometrist

WELCOME

We sincerely appreciate you choosing us for your eye care needs and we look forward to getting to know you. This form includes important documents to read fully and complete as neatly as possible. Please also provide a valid photo ID and updated insurance card(s).

PATIENT REGISTRATION

LAST NAME _____ FIRST NAME_____ M.I._____

ADDRESS_____ CITY_____ ST_____ ZIP_____

HOME PHONE (____) _____-_____CELL (____)_____-_____WORK (____)_____-____

E-MAIL_____

SOCIAL SECURITY NUMBER_____-_____-_____ DATE OF BIRTH____/____/_____

SEX_____ MARITAL STATUS_____ ETHNICITY ◯Hispanic OR ◯Non-Hispanic

(Please check)

☐ African American ☐ American Indian or Alaska Native ☐ Asian
☐ Asian Indian ☐ Caucasian ☐ Hattian
☐ Middle Eastern ☐ Other _____ ☐ I wish not to disclose

EMPLOYMENT INFORMATION

EMPLOYER NAME_____

EMPLOYER ADDRESS_____

☐ RETIRED ☐ NOT EMPLOYED

EMERGENCY CONTACT INFORMATION

NAME_____ PHONE (____) _____-_____

LAST NAME _____FIRST NAME _____DOB:_____/_____/_____

REASON FOR VISIT_____

Is this visit for a ***Work Related Injury***? YES ◯ NO ◯

IF YES:

EMPLOYER NAME_____

EMPLOYER ADDRESS_____ CITY_____ ST_____ ZIP_____

DATE OF INJURY _____

WORK COMP INSURANCE CARRIER_____

WORK COMP CLAIM #_____

WORK COMP CASE MANAGER_____ PHONE (____) _____-_____

DOCTOR CARE & PHARMACY INFORMATION

PRIMARY CARE PHYSICIAN (PCP)_____

REFERRING PHYSICIAN (*if different than PCP, possibly a specialist*)_____

☐ DO NOT HAVE A PRIMARY PHYSCIAN

LOCAL PHARMACY _____ LOCATION _____

Merritt Island
1045 N Courtenay Pkwy
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321-453-3937

Melbourne
232 S Wickham Rd
Melbourne, FL 32904
321-953-3937

Port St. John
6725 N Highway US 1
Cocoa, FL 32927
321-383-3937

Suntree
6559 N Wickham Rd #101C
Melbourne, DL 32940
321-723-3937

EYE CLINIC
& LASER INSTITUTE

MEDICAL HISTORY

LAST NAME _____FIRST NAME _____DOB:_____/_____/_____

Height:_____ Weight: _____

List **ALL** medications you are currently taking. Use back if need more room or attach list.

_____

_____

_____

List **ALL** of your allergies. Use back if more room is needed.

_____

_____

_____

PLEASE CHECK ALL THE EYE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

☐ Redness	☐ Eye Pain/Soreness	☐ Chronic infection of eye or lids
☐ "Tired" eyes	☐ Mucous discharge	☐ Sandy or gritty feeling
☐ Dry eye feeling	☐ STYES/Chalazion	☐ Light sensitivity
☐ Itching/Burning	☐ Fluctuating visual acuity	☐ Other: _____

Do you use lubricating eye drops? YES ☐ NO ☐
If YES, What brand name? _____

Do you wear glasses? YES ☐ NO ☐
If YES, How long have you worn them for?_____

Do you wear contact lenses? YES ☐ NO ☐
If **YES**, Are they comfortable? YES ☐ NO ☐
How long have your worn contacts? _____
If **NO**, Have you tried wearing them before & discontinued use? YES ☐ NO ☐

Have you ever had an eye injury? YES ☐ NO ☐
Please Describe: _____

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EYE CLINIC
& LASER INSTITUTE

HEALTH HISTORY

LAST NAME _____FIRST NAME _____DOB:_____/_____/_____

Please indicate if you or a blood relative have or have had any of the following conditions

	SELF	FAMILY	If Yes for Family, What Relationship
Macular Degeneration	YES / NO	YES / NO	_____
Glaucoma	YES / NO	YES / NO	_____
Diabetes	YES / NO	YES / NO	_____
High Blood Pressure	YES / NO	YES / NO	_____
High Cholesterol	YES / NO	YES / NO	_____
Heart Disease	YES / NO	YES / NO	_____
Headaches/Migraines	YES / NO	YES / NO	_____
Infectious Disease	YES / NO	YES / NO	_____
Cancer	YES / NO	YES / NO	
Type:_____			_____
Asthma/Respiratory	YES / NO	YES / NO	_____
Arthritis	YES / NO	YES / NO	_____
Epilepsy	YES / NO	YES / NO	_____
Stroke	YES / NO	YES / NO	_____
Allergies	YES / NO	YES / NO	_____
Gastrointestinal/Liver	YES / NO	YES / NO	_____
Blood Disorder	YES / NO	YES / NO	
Type:_____			_____
Kidney Stones	YES / NO	YES / NO	_____
Kidney Failure	YES / NO	YES / NO	_____
Pregnant / Nursing	YES / NO	YES / NO	_____
Prostate Disease	YES / NO	YES / NO	_____

SOCIAL HISTORY

Do you Smoke?	YES / NO	If YES, How many packs per day _____
Do you Drink Alcohol?	YES / NO	If YES, How many drinks per day_____
Do you use Illegal Drugs? (Cocaine, etc)	YES / NO	

I attest the information I provided is true and correct to the best of my knowledge.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

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EYE CLINIC
& LASER INSTITUTE

INSURANCE INFORMATION

LAST NAME _____ FIRST NAME_____ DATE OF BIRTH____/____/_____

PRIMARY INSURANCE CARRIER _____

ID#_____GROUP# (*if applicable*) _____

ADDRESS_____CITY_____ ST____ ZIP _____
(*if copy of insurance card is provided, address is not needed*)

SECONDARY INSURANCE CARRIER_____

ID#_____GROUP# (*if applicable*) _____

ADDRESS_____CITY_____ ST____ ZIP _____
(*if copy of insurance card is provided, address is not needed*)

Insured Information if NOT Patient

INSURED NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS_____CITY_____ ST____ ZIP _____

HOME PHONE (____) _____-_____CELL (____)_____-_____WORK (____)_____-____

E-MAIL_____

RESPONSIBLE PARTY'S D.O.B __/___/____ SOCIAL SECURITY NUMBER ____-____-_____

FINANCIAL POLICIES AND DISCLOSURE

Please read and sign the policies based on the payment method you are using today, please continue to *your* section on the following pages

(Medicare, Medicaid, Self Pay, or Commercial Insurance)

☐ MEDICARE *(Skip this page if you use Medicaid, Self Pay or have Commercial Insurance)*

_____ **Initial** I understand I am responsible for the Medicare deductible each calendar year. If I have not met my deductible for the year payment of services is due on the same day of examination.

_____ **Initial** I understand Medicare pays 80% of their allowed charge and the remaining 20% is my responsibility.

_____ **Initial** I understand that Medicare prohibits physicians and suppliers from collecting more than the allowable charge for services; it does not prohibit billing for non-covered services.

_____ **Initial** I understand that fees for medical eye exams vary depending on the level of service provided by the physician. Any additional tests or procedures will be charge and billed as allowed by Medicare.

_____ **Initial** I understand that billing for non-covered services applies to services that are normally not covered by Medicare, such as annual or routine physicals, as well as services that are denied as not medically necessary. Some examples of non-covered services which I would be finically responsible for are: Eye Refraction (92015), Contact Lens Fitting, Medications, and Cosmetic Procedures

_____ **Initial** I understand that I am finically responsible for any services that are denied by Medicare or are non-covered services

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or Other information about me to release to the Social Security Administration or its intermediaries of carries any information needed for Insurance related claims. I request that the payment of authorized benefits be made on my behalf to the physicians and /or organization.

Patient Signature _____ **Date** ___/___/_____

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FINANCIAL POLICIES AND DISCLOSURE

Please read and sign the policies based on the payment method you are using today, please continue to your section on the following pages
(Medicare, Medicaid, Self Pay, or Commercial Insurance)

☐ MEDICAID *(Skip this section if you Self Pay (see below) or have Commercial Insurance)*

_____ **Initial** I understand that Medicaid prohibits physicians and suppliers from collecting more than the allowable change for services; it does not prohibit billing for non-covered services.

_____ **Initial** I understand that I am finically responsible for any services that Medicaid does not consider medically necessary and does not reimburse.

_____ **Initial** I understand that billing for non-covered services applies to services that are normally not covered by Medicaid, such as annual or routine physicals, as well as services that are denied as not medically necessary.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

Witness_____ **Date** ___/___/_____

☐ SELF PAY *(Skip this section if you have Commercial Insurance, see next page)*

_____ **Initial** I understand that I am financially responsible for any charges for services provide at the time of exam. I do not have insurance and will pay out of pocket for all expenses. No insurance claims will be filled.

We accept cash, check, major credit cards, and Care Credit.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

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Merritt Island, FL 32953	Melbourne, FL 32904	Cocoa, FL 32927	Melbourne, DL 32940
321-453-3937	321-953-3937	321-383-3937	321-723-3937

FINANCIAL POLICIES AND DISCLOSURE

Please read and sign the policies based on the payment method you are using today, please continue to your section on the following pages

(Medicare, Medicaid, Self Pay, or Commercial Insurance)

☐ COMMERCIAL INSURANCE

_____ **Initial** I authorize Aggarwal Medical Associates to release information to my Insurance Company and to file insurance claims for treatment rendered. I understand that I will be responsible for the charges incurred in the event that my insurance company does not pay, a claim is denied, or in the event that my insurance company would go out of business.

_____ **Initial** I understand that insurance billing is a service provided as a courtesy and filing an insurance claim does not relieve me of the financial responsibility of any charges incurred.

_____**Initial** I agree to assign benefits to Aggarwal Medical Associates and authorize Aggarwal Medical Associates to receive payments for services rendered.

_____**Initial** I understand that exact insurance benefits cannot be determined until the insurance company receives the claim.

_____**Initial** I understand that I am accepting full financial responsibility for all medical services and or supplies received.

_____**Initial** I understand any co-payment of the eye examination is due on the day of service.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

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EYE CLINIC POLICIES AND PATIENT INFORMATION

REFRACTION: If you choose to be checked to receive an eye glass prescription (known as refraction) there will be a $35.00 fee. This fee is totally independent of whether the prescription changed. This fee also applies to those having a contact lens exam.

CONTACTS RENEWAL: To receive a renewed contact lens prescription (valid for 1 year) you need to wear your existing contacts to the exam. The fee will be $40-$60 (based on type of lens, for mild prescription change) in addition to a regular exam and Refraction fee ($35). This applies for returning patients who are not changing the type of contacts they use.

CONTACTS NEW FIT: A New Fit Exam is for those who have never worn contacts and wish to receive a contact lens prescription; valid for 1 year. The fee will be $60-$120 (based on type of lens) in addition to a regular exam and Refraction fee ($35). This fee covers the initial evaluation and contact lens fit related follow up visit within one month of appointment. Contact lens training for those needing instructions for insertion, removal and lens care is included.

CONTACTS REFIT: A Refit Exam is for those who wish to change the type or brand of contacts they use and receive a new contact lens prescription; valid for 1 year. There will be a charge of $60-$120 (based on type of lens) in addition to a regular exam and Refraction fee ($35). This fee covers the initial evaluation and contact lens fit related follow up visit within one month of appointment. Contact lens training for those needing instructions for insertion, removal and lens care is included.

REFERRAL: It is your responsibility to get an authorization for your visits, should your insurance require it. Should you fail to do so and the insurance does not pay, it will be your responsibility to pay the amount due.

FORMS: There is a $25 processing fee if you need any of the following forms completed: Family Medical Leave Act forms (FMLA), School or Camp, Long Term Care, Life Insurance, Department of Veteran's Affairs, Driver's License Eligibility

NO SHOW / NO CANCEL: If you do not show up for your appointment or if it is not cancelled at least 24 hours in advance, you will be charged a $50 fee. This will not be covered by your insurance company.

LATE ARRIVAL: If you are more than 15 minutes late for your appointment we have the right to cancel your appointment. This is done at the discretion of the staff based on the schedule.

I have read the above statements and understand and agree to the information.
I understand that policies are subject to change.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment or health information.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

Witness_____ **Date** ___/___/_____

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CONTACT RECORD

LAST NAME _____FIRST NAME _____DOB:_____/_____/_____

It is our policy to leave confidential messages on your answering machine, with family members or other individual when you are not available unless you inform us otherwise.

Limited information will be disclosed. For example, when calling we will only leave our name, number or other information necessary to confirm an appointment.

Eye Clinic uses **phone call** as a primary means of communication

Please List your Contact Numbers in order of Preference

PRIMARY PHONE (____) _____-_____ Type of Phone ◯Home ◯Cell ◯Work

SECONDARY PHONE (____) _____-_____Type of Phone ◯Home ◯Cell ◯Work

Eye Clinic uses **email** to communicate messages and clinic information

I give permission to Eye clinic to contact me by email: ◯YES ◯NO

Email _____

Eye Clinic uses **text message** to communicate messages and clinic information when available

I give permission to Eye clinic to contact me by text: ◯YES ◯NO

I **authorize** Eye Clinic to speak with the following about my healthcare:

☐ NO ONE ☐ SPOUSE: _____

☐ CHILD: _____ ☐ OTHER: _____

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service.

I understand and agree to the communication policies of Eye Clinic & Laser Institute.

Patient Signature (or Parent if Minor) _____ **Date** ___/___/_____

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SPEED™ QUESTIONNAIRE

Last Name: **First Name:** **Date:** /

Sex: M ◯ F ◯ **DOB:**

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ **YES** ☐ **NO** **If yes, how often?**

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For offce use only
Total SPEED score (Frequency + Severity) =____/28

HOW DID YOU HEAR ABOUT US?

We appreciate knowing how you heard about us and it helps us to acknowledge those (especially your doctor) who refer you to us.

LAST NAME _____FIRST NAME _____DATE:_____

Please check ALL that apply

☐ Doctor Referral
Doctor's Name _____

☐ TV ☐ Newspaper

☐ Google ☐ Facebook

☐ Instagram

☐ Savings Safari (postcard/mail)

☐ Website (www.youreyeclinic.com)

☐ Insurance Plan Directory

☐ Other, please specify _____

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EYE CLINIC
& LASER INSTITUTE

*Eye Clinic & Laser Institute is proud to offer medical spa services through our partner **Neo Laser Medical Spa**.*
Please take a moment to look at the services they offer and let us know if we can provide your information about our services to help you look and feel your best.

Neo LASER
MEDICAL SPA SERVICES

Two Locations to Serve your Beauty Needs

1045 N. Courtenay Pkwy, Merritt Island FL 32935
6559 N Wickham Rd #102, Melbourne FL 32940
321-459-9033 • www.neolaserspa.com

Cosmetic Interest Survey

Consultations for all procedures and services are **complementary** and pricing varies by individual; all packages will be provided by an in person consultation.

Please CHECK the box to indicate your interest

◯ I am not interested at this time ◯ Please contact me

Last Name_____ First Name_____

Email Address* _____ Phone* _____

Best Way to be reached ◯ *Phone* ◯ *Email*

☐ Non-Invasive Fat Reduction
☐ Wrinkle Reduction
☐ Smart Lipo (fat removal)
☐ Brown Spots / Age Spots
☐ Hyperpigmentation
☐ Skin Tightening / Rejuvenation
☐ Microdermabrasion
☐ Hair Thinning / Hair Loss
☐ Laser Hair Removal
☐ Laser Tattoo Removal
☐ RF Microneedling
☐ Rosacea
☐ Acne
☐ Scarring
☐ Facials
☐ Spider Veins

*By providing your contact email/phone you agree to be contacted by Neo Leaser Medical Spa and to be included in promotional information about our services and products.