DANGLES EYE CENTER

Dr. George J. Dangles, M.D.

Dr. Laura K. Sanders, M.D.

PLEASE CIRCLE: DR. MR. MRS. MISS. MS.

PATIENT NAME: _____ BIRTHDATE: ____/____/____

ADDRESS: _____ SOCIAL SECURITY #:

CITY/STATE/ZIP: _____ _____

HOME PHONE: _____ MALE _____ FEMALE _____

WORK PHONE: _____ MARITAL STATUS:

CELL PHONE: _____ S____ M____ W____ D____

EMAIL ADDRESS: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE #: _____

WHO REFERRED YOU TO OUR OFFICE? _____

(X)

_____

(SIGNATURE)

_____

I REQUEST THAT PAYMENT OF MEDICARE AND/OR INSURANCE BENEFITS BE MADE PAYABLE DIRECTLY TO GEORGE J. DANGLES, M.D., P.C. FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. **I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES.**

DANGLES EYE CENTER

11845 Southwest Highway
Palos, Heights, IL 60463
Phone: (708) 274-8700

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Privacy Official: Elene Dangles

Print Name of Patient: X_____

Signature of Patient: X_____

Date: X_____

Patient's Date of Birth X_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship: _____

(parent, guardian, etc.)

Signature of Personal Representative: _____

Date: _____

For Practice Use Only:

_____ _____

Signature of Practice Employee Date

DANGLES EYE CENTER
11845 Southwest Highway
Palos, Heights, IL 60463
Phone: (708) 274-8700

OFFICE REFRACTION POLICY

A "refraction" is the process of determining the optimal eyeglass prescription for your eyes. This is not only to allow us to prescribe eyeglasses, but more importantly to determine your best corrected vision. The refraction helps us to distinguish whether vision problems are caused by glasses or from eye disease.

A refraction may or may not be performed at the time of your visit, depending upon doctor's judgment of its necessity. This service is not covered by Medicare and by most private insurances. If a refraction is performed, there will be a fee of $40.00.

It is our policy to collect the refraction fee at the time of service. As a courtesy to you, we will submit this charge to your insurance. Should there be a payment, we will be happy to reimburse you.

I have read and understand the office policy on refraction. I also understand that this policy will apply to all my future visits.

_____ _____

Signature Date

George J. Dangles, M.D., P.C.

Confidential Medical Questionnaire

Name: _____ Date:_____

Do you <u>currently</u> have any problems in the following areas? Please mark YES or NO

EYES:

Decreased vision at distance	YES	NO
Decreased vision at near	YES	NO
Distorted vision (halos)	YES	NO
Fluctuating vision	YES	NO
Tired eyes	YES	NO
Flashing lights	YES	NO
Glare/light sensitivity	YES	NO
Night blindness	YES	NO
Floaters	YES	NO
Dryness, mucus discharge	YES	NO
Redness	YES	NO
Sandy or gritty feeling	YES	NO
Burning	YES	NO
Foreign body sensation	YES	NO
Pain or soreness	YES	NO
Chronic infection of eye or lid	YES	NO
Sties or chalazion	YES	NO
Blindness	YES	NO

Ear, Nose, Mouth, and Throat:

Sinus congestion	YES	NO
Runny Nose	YES	NO
Dry mouth/throat	YES	NO

Respiratory:

Asthma	YES	NO
Emphysema	YES	NO
Chronic cough	YES	NO

Cardiovascular:

Heart attack	YES	NO
High Blood Pressure	YES	NO
Pacemaker	YES	NO
Bypass	YES	NO
Chest pains	YES	NO
High cholesterol	YES	NO

OTHER _____

ARE YOU PREGNANT? _____

Hematological/Lymphatic:

Blood disorders	YES	NO
Anemia	YES	NO
Slow clotting time	YES	NO

Gastrointestinal:

Stomach/Intestines	YES	NO

Skin:

Eczema, psoriasis	YES	NO
Herpes	YES	NO

Genitourinary:

Bladder	YES	NO
Kidneys	YES	NO

Endocrine:

High Blood Sugar	YES	NO
Low Blood Sugar	YES	NO
Diabetes	YES	NO
Insulin	YES	NO
Pills	YES	NO
Thyroid	YES	NO

Musculoskeletal:

Bones/Joints/Muscles	YES	NO

Neurological:

Blackout	YES	NO
Headache/Migraine	YES	NO
Stroke	YES	NO
Palsy	YES	NO

Psychological:

Depression	YES	NO
Anxiety	YES	NO

CONFIDENTIAL MEDICAL QUESTIONAIRE

Name: _____ Date: _____

FAMILY HISTORY: (not yourself)			**PATIENT HISTORY: (YOU)**		
Glaucoma	YES	NO	Glaucoma	YES	NO
Blindness	YES	NO	Cataracts	YES	NO
Cancer	YES	NO	Macular Degeneration	YES	NO
Hypertension	YES	NO	Diabetic Retinopathy	YES	NO
Thyroid	YES	NO	Retinal Detachment	YES	NO
Cataract	YES	NO	Crossed Eyes	YES	NO
Crossed Eye	YES	NO			
Diabetes	YES	NO			
Kidney	YES	NO			
Stroke	YES	NO			

SOCIAL HISTORY:

DO YOU SMOKE? _____ YES _____NO HOW MUCH? _____

DO YOU DRINK ALCOHOL? _____ YES _____ NO HOW MUCH? _____

DO YOU USE DURGS OR MEDICATIONS **NOT** PRESCRIBED BY YOUR DOCTOR?
_____ YES _____ NO IF SO, WHAT? _____

PAST HISTORY:

PLEASE LIST ANY **MEDICATIONS** THAT YOU ARE TAKING?

_____

PLEASE LIST ANY **SURGERIES** YOU HAVE HAD AND WHEN THEY WERE PERFORMED?

_____

PLEASE LIST ANY **ALLERGIES** THAT YOU HAVE?

_____

WHAT IS THE NAME OF YOUR FAMILY DOCTOR?

_____

TODAY'S DATE: _____

REVIEWED BY: _____ _____

George J. Dangles, M.D. **Laura K. Sanders, M.D.**