



Cottone Family Eyecare
Francis X. Cottone, OD, FAAO
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Phone 773.585.2022
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www.cottone.com

Welcome! We look forward to seeing you for your appointment! Enclosed / attached you will find informational forms that we would like you to complete prior to your first visit. Please mail, e-mail, fax, or bring them with you to your appointment. In accordance with new identity theft laws we ask that you have two current forms of identification one needing to be a photo ID, other forms of ID that we would accept are Credit cards, utility bill, passport or birth certificate, for under age patients we would need parents ID. Your clear understanding of our office policy is important. Please call with any questions.

Your First Visit

Since you are a new patient to our practice, we will dilate your pupils with drops which will allow us to evaluate the health of your eyes. There is no substitution for this test! These drops will temporarily make your eyes more sensitive to light and may blur your near vision for a period of time after your exam.

Vision Insurance

Prior to exam it is the patient's responsibility to provide insurance information to determine vision coverage type and plan. Please bring your insurance card on your first visit so that it may be scanned into your digital file. It is a good idea to bring your card on every visit. If your insurance ever changes, it is especially important to let us know and for you to bring your new card. Please arrive 15 minutes before your first appointment time so that all paper work can be completed.

Self-Pay Patients

If we are not a provider for your vision insurance plan or you do not have vision insurance, full payment is due at the time of service. We will provide you with a receipt in which you may use to file the insurance claim yourself.

Medicare

Dr. Cottone is a Medicare provider. All Medicare patients are responsible for their 20% co-pay, annual deductible and any non-covered services.

Under-aged Patients

All minor patients (less than 18 years of age) must be accompanied by their parent, legal guardian or an authorized adult on their first visit. A consent form must be signed to have a minor between the ages of 16-18 seen without their parent or legal guardian present. If under the age of 16, the patient may only be seen with a parent, legal guardian or authorized adult present.

Payment

Payments may be made by cash, Visa, MasterCard, or Discover we also accept care credit. A cashier's check or money order will be accepted in lieu of cash.

Missed Appointments

Your appointment is a time that has been set aside especially for you. We understand that situations present themselves which may make it impossible for you to make that appointment therefore we make every effort to verify or confirm this time with you. So, in fairness to everyone, we do require a 24 hour notice in the event you are unavailable for this special time. If this requirement is not met we reserve the right to charge a fee of \$25.00.

Scheduling

Patients are not always called in order of arrival due to the fact that appointments may be with Doctor Cottone or office staff. We make every effort for you to be seen at your scheduled time; however, unforeseen emergencies, complicated or unusually ill patients may cause us to run behind. Please be understanding in that someday your emergency or illness may affect others.

You may refer to our website for further information @ www.cottone.com

By Signing below means that you have received and understood this notice.

Signature

Date

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askus@cottone.com

Medical History Questionnaire

Dear Patient:

Federal law requires us to obtain in depth patient medical history information. This information allows us to provide you with the best care possible. We apologize for the time required to fill out this form and thank you for your cooperation.

Name: _____ Today's Date: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Social Sec. #: _____ Sex: _____
Date of Birth: _____ Age: _____
Employer: _____ Occupation: _____
Insured's Name: _____ Insured's Soc. Sec. #: _____
Primary Care Physician: _____ Last Medical Exam: _____
Last Eye Doctor: _____ Last Eye Exam: _____
May we save trees by using email? yes no Email Address: _____

Who referred us to you? _____

Marital Status Single Married Divorced Widow/Widower

Medical History

Reason for Visit: annual exam new glasses lost/broken glasses contacts interested in laser vision correction

Do you have any specific questions or problems you would like to discuss with Dr. Cottone? If yes, please explain: _____

Are you pregnant and/or nursing? yes no

Please list any medications you are allergic to: _____

Please list any medications you are currently taking: _____

Personal Eye History

Have you ever worn glasses? yes no If yes, how old are your current glasses? _____

Do you currently wear contact lenses? yes no

Type of contact lenses: disposables gas permeable soft bifocal other _____

Have you had LASIK or refractive surgery? yes no If yes, list the date of surgery: _____

Have you had any other form of eye surgery? yes no If yes, please describe: _____

Check any of the following that you have had: crossed eyes lazy eye drooping eye lid
 prominent eyes glaucoma retinal disease
 cataracts eye injury serious eye infection

How many hours a day are you on the computer? _____

Social History

This information is kept strictly confidential. Please answer all questions that apply.

Do you drive? yes no If yes, do you have visual difficulty when driving? yes no

If yes, please describe: _____

Do you use tobacco products? yes no Do you drink alcohol? yes no Do you use illegal drugs? yes no

Please turn this form over and complete side two.

Review of Systems

Do you currently or have you ever had any serious problems in the following areas:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (Headaches)	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat (Allergies)	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immune	<input type="checkbox"/>	<input type="checkbox"/>	Mental	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

If you answered yes to any of the above or are currently under the care of a physician for any condition not listed above, please explain:

Family History

Please note any family history (parents, grandparents, sibling, children; living or deceased) for the following conditions:

<u>DISEASE/CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>RELATIONSHIP TO YOU</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

Pupil Dilation

Dilation of the pupils by use of eye drops is recognized as a very integral part of a complete eye exam. The drops allow for a greater field of view by Dr. Cottone to assess not only the posterior portion of the eye, but the far periphery of the eye where many eye problems exist, such as retinal detachments, vascular anomalies, and other retinal degenerations. Some insurances will cover this procedure and some do not. If your insurance doesn't cover this procedure, there would be a nominal fee, just ask our preliminary tester.

The procedure takes approximately 15-20 minutes and the patient will experience the following symptoms most notable: light sensitivity and some blurry vision while doing near work which will last approximately 4-6 hours. Please take caution while driving!

- Please do the entire exam with dilation. I understand the ocular effects the drops may cause.
- I do not wish to have this procedure done today and will reschedule with the office within four weeks. I do not hold Dr. Cottone responsible for any ocular health problems which may go undetected.

Patient Signature

Date

Reviewed by: _____