PATIENT DEMOGRAPHIC INFORMATION

Patient Name _____

Date of Birth:_____Social Security #_____-_____-_____ ☐Male ☐Female

Address _____

City_____State_____Zip Code _____

If Nursing Home/Assisted Living/Rehab resident, Name of Facility_____

Phone: Home (_____)_____Work (_____)_____Cell (_____)_____

Email Address: _____

☐ I authorize Florida Retina Specialists to leave messages for me concerning my appointments and eye care.

Employment: ☐Full-Time ☐Part-Time ☐Not Employed ☐Retired ☐Full-Time Student ☐Minor/Child

If employed, Place of Employment_____Occupation_____

Type(s) of Insurance _____

Marital Status ☐Single/Never Married ☐Married ☐Divorced ☐Widowed ☐Other_____

If patient is a minor, Mother's Name_____ Mother's Phone # _____

Father's Name_____ Father's Phone # _____

EMERGENCY CONTACT

Name_____Relationship _____

Phone: Home (_____)_____Work (_____)_____Cell (_____)_____

Referring Physician _____

Person(s) to Whom Medical Information May Be Released _____

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance at the time of your examination.**

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. This assignment will remain in effect until revoked by me in writing. A photocopy or digital image of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. In the event of default in the payment of my charges, I agree to pay all costs of collections, including reasonable attorney's fees if applicable.

4. I understand that Florida Retina Specialists is part of an organized healthcare arrangement, and that these providers may share my health information for treatment, billing, healthcare operations, and research purposes. I have been given a copy of their Notice of Privacy Practices that describes how my health information is used and shared. I understand that Florida Retina Specialists has the right to change this notice at any time. I may obtain a current copy by contacting the office.

X_____ _____

Patient's/Legal Guardian's Signature *(must be 18 years of age or older)* *Date*

Patient Name: _____

FLORIDA RETINA SPECIALISTS

CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operation that may be used by the attending doctor, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of all services. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee.

I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that my insurance will be submitted by this office and I will be responsible for paying all copays and/or deductibles at the time of visit.

I understand that if my insurance is an HMO, that I must obtain a referral from my Primary Care Physician every visit before coming to this office for any appointments. I understand that it is my responsibility as the patient to confirm that my referral is current and in effect when I arrive for my appointment. If no referral is obtained, I will pay for the visit.

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided by our physicians.

By signing below, I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

DILATING EYE DROPS

Please read this important information carefully:
Dilating eye drops are used to enlarge (dilate) the pupil of the eye to allow the ophthalmologist (eye doctor) to view the inside of the eye and perform a thorough examination of the retina. The retina cannot be completely observed without the use of these drops. Dilating drops usually blur the vision for a length of time that varies from person to person (up to several hours) and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Driving must be avoided immediately following your examination and you should not drive until the effects of the dilating drops have worn off.

By signing below, you acknowledge an understanding that dilating drops will be used in your eyes at this visit and **EACH** future appointment you may have at Florida Retina Specialists. Further, you understand that another person needs to be available at all visits to drive you home.

X_____ _____

Patient's / Legal Guardian's Signature *Date*

FLORIDA RETINA SPECIALISTS

Patient Name: _____

Date of Birth: _____ Age: _____

MEDICAL INFORMATION

Date: _____

PHYSICIANS (name and location)

Ophthalmologist/Optometrist (eye): _____

Primary Care (family): _____

Cardiologist (heart): _____

Other (i.e. Endocrinologist, etc.) _____

PHARMACY

Name: _____

Location: _____

Telephone: (____) _____

MEDICATION: List the medicines you take regularly and dosages/schedule (including eye drops):

☐ **See attached list**

_____

_____

_____

_____

DRUG ALLERGIES/REACTION: _____

I have received the vaccination for:

○ *FLU (influenza) Date:* _____ ○ *Pneumonia (pneumococcal) Date:* _____

PAST EYE HISTORY

Known eye diseases: _____

Previous eye surgeries OR injuries: _____

FAMILY HISTORY (list blood relatives only):

			IF **YES**, relationship to patient? (M=mother, F=father, S=sister, B=brother, etc.)
Retinal detachment	Y	N	_____
Age–related macular degeneration	Y	N	_____
Glaucoma	Y	N	_____
Rheumatoid Arthritis	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Heart disease	Y	N	_____
High blood pressure	Y	N	_____
Stroke	Y	N	_____
Lupus	Y	N	_____

Patient Name: _____

SOCIAL HISTORY

Do you currently smoke? Y N If **YES**: □occasional □ ½ pack/day □ 1+pack/day

If **NO**, have you ever smoked? Y N If **YES**: number of years?_____when did you quit? _____

Do you drink alcohol? Y N If **YES**: □occasional □ 1/day □ 2-3/day □ 4+/day

Do you currently use smokeless tobacco or recreational drugs? Y N If **YES**: number of years? _____

PREVIOUS SURGERIES (of the body): _____

_____

Endocrine:
- ◯ Diabetes *How long? _____
  - ◯ *Diet controlled*
  - ◯ *Diet plus oral medicines*
  - ◯ *Diet and insulin*
- ◯ Thyroid disease
  - ◯ *Hypothyroid*
  - ◯ *Hyperthyroid*
- ◯ High Cholesterol

Heart:
- ◯ High Blood Pressure
- ◯ Valvular Heart Disease
- ◯ Coronary Artery Disease
- ◯ Atrial Fibrillation (irregular heart beat)
- ◯ History of heart attack
- ◯ Pacemaker or Defibrillator device
- ◯ Other: _____

Cancer:
- ◯ History of Cancer?

Type/treatment _____
_____

Nervous:
- ◯ Stroke
- ◯ Seizures
- ◯ History of anxiety or panic attacks

Bone/Joint:
- ◯ Arthritis

Type _____

Blood:
- ◯ Anemia
- ◯ Sickle cell trait
- ◯ Hemoglobin C disease
- ◯ Free bleeder
- ◯ HIV/AIDS

Lungs:
- ◯ Asthma
- ◯ Chronic bronchitis

Stomach/Intestine:
- ◯ Reflux disease
- ◯ Ulcer disease
- ◯ Liver disease
- ◯ Hepatitis: A, B, or C _____
- ◯ Gall bladder disease

Kidney/Urinary:
- ◯ Kidney failure
- ◯ On dialysis

Other problem not listed:

Office Use Only: Technician Signature:_____Date: _____