ASSOCIATES IN EYE CARE OF FLORIDA

Licensed experts who genuinely care about you and your eye care

Date:_____

Last Name_____ First_____ MI____ DOB_____ M or F

Local Address_____ City_____ ST_____ Zip_____

E-mail Address_____ SS#_____Marital S M D W

Primary Phone#_____ Home or Cell Other Phone#_____

Best way of reminding you of your appointment: Home phone___ Text via cell___ Email___

How did you hear about our office:_____

(IE: internet, insurance, friend, relative, phone book)

INSURANCE INFORMATION (We will scan the front/back of your insurance cards)

Primary Insurance_____ Secondary Insurance_____

Vision Insurance_____

If you are working, Employed by:_____

If retired is Medicare your primary insurance? Yes or No

RESPONSIBLE PARTY (IF PATIENT IS RESPONSIBLE, CHECK HERE ____)

Last name_____ First_____ SS#_____ DOB_____

Relationship to patient_____ Primary Phone#_____ Home or Cell

Are You Interested in Contact Lenses? _____Yes _____No

Are You Planning To Purchase Eyewear Today? _____Yes _____No

What sports or hobbies do you enjoy?

__Reading	__Computer work	__Playing cards	__Sewing
__Boating	__Golfing	__Fishing	__Baseball
__Tennis	__Soccer	__Cooking	__Crafts
__Hunting	__Gardening	Other _____	

PATIENT HISTORY

CONDITIONS	YOU	MOTHER	FATHER	BROTHER	SISTER	GRANDPA	GRANDMA
ALLERGIES							
ARTHRITIS							
ASTHMA							
DIABETES							
HEART DISEASE							
HYPERTENSION							
HIGH CHOLESTEROL							
STROKE							
THYROID DISEASE							
CATARACT							
GLAUCOMA							
MACULAR DEGENERATION							

HEIGHT:_____

WEIGHT:_____

SMOKING: YES NO IF YES HOW MUCH?_____ HOW LONG?_____

QUIT SMOKING WHEN?_____

ALCOHOL USE: NONE SOCIAL 1-2 DAILY ABOVE AVERAGE DEPENDENT

LIST MEDICATIONS TAKEN:

_____

_____

_____

_____

ALLERGIES:_____

_____

EYE SURGERIES AND DATES:_____

ARE YOU CURRENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

__ BLURRY VISION

__ BURNING

__ DISCHARGE

__ DOUBLE VISION

__ DRYNESS

__EXCESS TEARING/WATERY

__ EYE INFECTION

__ EYE PAIN OR SORENESS

__ FLOATERS OR SPOTS

__ HALOS

__ ITCHING

__ LIGHT FLASHES

__ LIGHT SENSITIVITY

__ REDNESS

__ SANDY OR GRITTY FEELING

__ OTHER

LIFETIME CONSENT FOR RELEASE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

Date:_____

Last Name:_____ First:_____ MI:_____

DOB:_____

I hear-by authorize Associates In Eye Care of Florida to disclose my Protected Health Information (PHI) to the noted individuals:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

I authorize the release of any medical information necessary for my treatment and to process claims as well as authorization of payment directly ti Associates In Eye Care of Florida. **PLEASE NOTE:** This authorization shall become effective immediately and shall remain in effect for a lifetime.

The undersigned represents that he/she has read and understands the information contained here, and that they agree to the conditions of this Authorization.

I acknowledge that I am aware of the Notice of Privacy Practices (HIPPA) for this office.

I understand that I am responsible for knowing if my insurance requires a referral and for obtaining such referral from my primary care physician.

I am financially responsible for all co-pays, deductibles, and charges not covered by insurance.

_____ _____

Patient Signature **Date**