FLORIDA EYE SPECIALISTS & CATARACT INSTITUTE

ACCOUNT NUMBER: ____________________ DATE: ____________________

HOME: ____________________

PATIENT'S NAME: ____________________ CELL: ____________________

PATIENT'S ADDRESS: ____________________
street city state zip

SECOND OR SUMMER ADDRESS: ____________________
street city state zip

EMAIL ADDRESS: ____________________

PATIENT'S AGE: __________ DATE OF BIRTH: ____________________ SOC. SEC.#: ____________________

MARITAL STATUS: ____ S ____M ____ W ____ D SEX: F ___ M ___ SPOUSE'S NAME: ____________________

PERSON RESPONSIBLE FOR BILL: ____________________ SPOUSE'S/PARENT'S SOC. SEC. #: ____________________

AND DATE OF BIRTH: ____________________

EMPLOYER'S NAME AND ADDRESS: ____________________ PHONE: ____________________
OR FATHER'S (IF PATIENT IS A MINOR) EXT.: ____________________

SPOUSE'S EMPLOYER AND ADDRESS: ____________________ PHONE: ____________________
OR MOTHER'S (IF PATIENT IS A MINOR) EXT: ____________________

REFERRED BY: ____________________ RELIGION: ____________________

MEDICAL HISTORY

DO YOU HAVE?	HOW LONG?	DO YOU HAVE?	HOW LONG?
YES ____NO____ HIGH BLOOD PRESSURE	____________	YES ____ NO____ CANCER	____________
YES ____NO____ DIABETES	____________	YES ____ NO ____ EMPHYSEMA/ ASTHMA	____________
YES ____NO____ HEART TROUBLE	____________	YES ____ NO ____ ARTHRITIS	____________
YES ____NO ____STROKE	____________	YES ____ NO ____ THYROID PROB	____________
YES ____NO ____MIGRAINE HEADACHES	____________	YES ____ NO ____ KIDNEY DIS	____________
YES ____NO ____CATARACTS	____________	YES ____ NO ____ LIVER DIS	____________
YES ____NO ____GLAUCOMA	____________	YES ____ NO ____ STOMACH ULCERS	____________
YES ____NO ____OTHER EYE DISEASES	____________	YES ____ NO ____ ALCOHOL/ TOBACCO USE	____________

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE? ____________________
____

YES _____ NO _____ DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE ABOVE DISEASES?
IF SO, WHICH? ____________________

YES _____ NO _____ HAVE YOU HAD ANY EYE SURGERY? IF SO, WHAT, WHEN AND BY WHOM?
____

ROS Additions - Problems w
ENT = Hearing - Ear - Ache - Dry Mouth _______
GU = Stones Urination _______
GYN = Preg Nursing _______
SKIN = Cancers Rash _______
BLOOD = Leukemia Lymph Nodes Anemia _______
PSY = Depression - Insomnia - Anxiety _______
GEN = Fever - Tired - Wt - Change _______

YES _____ NO _____ DO YOU HAVE ANY ALLERGIES? IF SO, TO WHAT? ____________________
____

IF YOU WEAR GLASSES, WHEN WAS YOUR LAST CHANGE IN GLASSES? ____________________

WHEN WAS YOUR LAST EYE EXAMINATION? ____________________ BY WHOM? ____________________

WHAT SURGICAL OPERATIONS HAVE YOU HAD? ____________________
____

WHAT MEDICATIONS DO YOU TAKE, INCLUDING EYE DROPS? ____________________
____
____

Primary Care: ____________________ Pharmacy: ____________________

LIFETIME AUTHORIZATION
Medicare or Insurance Certification for Payment

I certify that the information given by me in applying for payment under Title XVII 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 or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services.

I request that this authorization also apply to any insurance other than Medicare. I also request that payment of authorized MEDIGAP/Supplemental benefits be made on my behalf to Florida Eye Specialists & Cataract Institute for any services furnished me by physicians of Florida Eye Specialists & Cataract Institute . I authorize any holder of medical information about me to release to Florida Eye Specialists & Cataract Institute and/or MEDIGAP/ Supplemental insurer any information needed to determine these benefits or the benefits payable for related services and/or to aid in my medical care.

INSURANCE DISCLAIMER: Due to the many different kinds of insurance companies, you are required to know your insurance coverage. Payment for all services rendered is your responsibility. This also applies to you if you choose to use an out of network physician at our facility under your HMO/PPO plan. I also, understand by signing, I am guaranteeing payment of this account (if insurance is billed and doesn't pay as well). Failure to pay on this account within 120 days will result in collections fees applied to this account balance, if any. $25.00 Fee

INFORMATION REGARDING DILATING· EYE DROPS

DILATION IS THE STANDARD OF CARE TO ALLOW THOROUGH EVALUATION OF EYE TISSUE FOR A NUMBER OF EYE CONDITIONS. The use of dilation drops temporarily increases the size of your pupils, which allows an eye physician to more accurately investigate the health of your eyes. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected, and because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. For a short time, wearing sunglasses may be a necessary comfort. Adverse reactions, such as acute angle-closure glaucoma may also be triggered and/or diagnosed by the dilating drops. Call our office immediately if you experience excessive pain, discomfort, nausea, or any other untoward symptoms. Thank you for your assistance during this important procedure.

By signing this form I hereby acknowledge that I am aware of the above information and authorize my physicians and/or their assistants to administer dilating eye drops to assist in the optimum evaluation of my eyes. My acknowledgment and authorization shall be without expiration, but I am aware that (as all other diagnostic or treatment procedures) AT ANY TIME I MAY ELECT TO NOT HAVE THIS IMPORT ANT PROCEDURE BY SIMPLY INFORMING THE TECHNICIAN AND/OR PHYSICIAN. If l elect to not use dilating drops for my examination, I also hereby affirm that I am aware that my decision may reduce the ability of my physician to optimally care for my eyes.

______________________________ Date ______________
Signed by Patient (or person authorized to sign for patient)

Medigap/Supplemental Signature: ______________________________

By: Self or *______________________________ Relationship ______________

______________________________ Date ______________
Witness

* If signed by other than beneficiary, state the reason patient was unable to sign:

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