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:

_____

FLORIDA EYE SPECIALISTS
& CATARACT INSTITUTE

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Florida Eye Specialists & Cataract Institute may use or disclose my protected health information for treatment, payment or health care operation-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Florida Eye Specialists & Cataract Institute has a detailed document called the ***'Notice of Privacy Practices'.*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

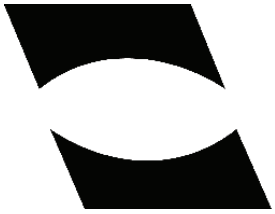
I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Florida Eye Specialists & Cataract Institute will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the notice of Privacy Practices. My signature means that I agree to allow Florida Eye Specialists & Cataract Institute to use and disclose my protected health information to carry our treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Florida Eye Specialists & Cataract Institute has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Florida Eye Specialists & Cataract Institute, 403 Vonderburg Drive, Brandon, Florida 33511.



FLORIDA EYE SPECIALISTS
& CATARACT INSTITUTE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care.)

_____

_____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Name_____Phone Number _____

Name_____Phone Number _____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”

YES_____ NO_____

Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than your home number.

_____

*** I am fully aware that a cell phone is not a secure and private line.**

Can confidential messages (i.e, appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME _____(guardian if under 18)

PATIENT SIGNATURE_____DATE_____