

WELCOME TO OUR OFFICE
PLEASE COMPLETE THE FOLLOWING INFORMATION

| PATIENT IDENTIFYING INFORMATION | | | | | | | |
|--|-------------------------------------|--|------------------|--|------------------|--|---|
| LAST NAME | | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | | FIRST NAME | | MIDDLE NAME | TODAY'S DATE |
| HOME ADDRESS | | | | | | | |
| CITY | | | | STATE | | ZIP | |
| HOME TELEPHONE | | | OFFICE TELEPHONE | | MOBILE TELEPHONE | EMAIL ADDRESS | |
| () | () | () | () | () | () | | |
| SEX | BIRTH DATE | | AGE | SOCIAL SECURITY NUMBER | | MARITAL STATUS | LIST FAMILY MEMBERS WHO ARE PATIENTS AT THIS OFFICE |
| <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE | | | | | | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | |
| EMPLOYER / (SCHOOL) | | | | OCCUPATION / (GRADE) | | | |
| HOW DID YOU HEAR ABOUT OUR OFFICE | | | | REFERRED BY | | NAME OF PERSON WHO REFERRED YOU | |
| <input type="checkbox"/> INSURANCE | <input type="checkbox"/> PHONE BOOK | <input type="checkbox"/> PREVIOUS PATIENT / ALTAMONTE | | <input type="checkbox"/> FRIEND | | | |
| <input type="checkbox"/> NEWSPAPER AD | <input type="checkbox"/> LOCATION | <input type="checkbox"/> PREVIOUS PATIENT / SANFORD | | <input type="checkbox"/> PRIMARY CARE DOCTOR | | | |

| IF PATIENT IS UNDER 18 YEARS OR STUDENT | | | | |
|--|--|----------------|----------------|------------------|
| NAME OF PARENT / GUARDIAN | | HOME TELEPHONE | WORK TELEPHONE | MOBILE TELEPHONE |
| NAME OF PERSON RESPONSIBLE FOR PAYMENT OF FEES | | HOME TELEPHONE | WORK TELEPHONE | MOBILE TELEPHONE |

| MEDICAL INFORMATION | | | | |
|--------------------------------|--|----------------------------|-------------------------------------|-----------------------|
| NAME OF PRIMARY CARE PHYSICIAN | | DATE OF LAST PHYSICAL EXAM | NAME OF PREVIOUS EYE CARE PHYSICIAN | DATE OF LAST EYE EXAM |

| EMERGENCY CONTACT | | | | |
|----------------------|--|------------------|------------------|------------------|
| SPOUSE / PARENT NAME | | OFFICE TELEPHONE | HOME TELEPHONE | MOBILE TELEPHONE |
| EMERGENCY CONTACT | | RELATIONSHIP | OFFICE TELEPHONE | HOME TELEPHONE |
| EMERGENCY CONTACT | | RELATIONSHIP | OFFICE TELEPHONE | HOME TELEPHONE |

| INSURANCE INFORMATION - VISION BENEFITS | | | | |
|---|--|-------------------------------|-----------------------------|-------------------------|
| NAME OF INSURANCE COMPANY - VISION COVERAGE | | POLICY HOLDER NAME (EMPLOYEE) | BIRTH DATE OF POLICY HOLDER | RELATIONSHIP TO PATIENT |
| GROUP NAME | | GROUP NUMBER | ID NUMBER | TELEPHONE NUMBER |

| INSURANCE INFORMATION - PRIMARY MEDICAL INSURANCE | | | | |
|---|--|-------------------------------|-----------------------------|-------------------------|
| NAME OF INSURANCE COMPANY - VISION COVERAGE | | POLICY HOLDER NAME (EMPLOYEE) | BIRTH DATE OF POLICY HOLDER | RELATIONSHIP TO PATIENT |
| GROUP NAME | | GROUP NUMBER | ID NUMBER | TELEPHONE NUMBER |

INSURANCE IDENTIFICATION

INSURANCE IDENTIFICATION AND A PICTURE ID IS REQUIRED FOR ALL PATIENTS.

- YOUR INSURANCE IDENTIFICATION CARD AND PICTURE ID WILL BE PHOTOCOPIED BEFORE THE EXAMINATION.
- PRIOR AUTHORIZATION FROM YOUR INSURANCE COMPANY IS REQUIRED BEFORE SERVICES ARE RENDERED.
- YOUR INSURANCE CLAIM CANNOT BE PROCESSED WITHOUT VERIFICATION OF ELIGIBILITY BY OUR OFFICE PRIOR TO YOUR EXAM.

OUR FINANCIAL POLICY

AS A COURTESY TO OUR PATIENTS, WE PARTICIPATE IN MANY HEALTH CARE INSURANCE PROGRAMS. INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR PROFESSIONAL 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. DEPENDING ON YOUR PLAN, YOU MAY BE REQUIRED TO PAY ANY OUTSTANDING BALANCE ON YOUR ACCOUNT.
- AS THE PATIENT, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR HEALTH INSURANCE POLICY BENEFITS AND OBLIGATIONS. THIS INCLUDES YOUR FINANCIAL OBLIGATIONS FOR SERVICES RENDERED BY THE PARTICIPATING PHYSICIAN AND OBTAIN PRIOR AUTHORIZATION WHEN NECESSARY.
- HEALTH CARE REGULATIONS REQUIRE THE COLLECTION OF ALL CO-PAYMENTS, DEDUCTIBLES, BALANCES AND NON-COVERED PROFESSIONAL FEES AT THE TIME OF SERVICE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.
- ALL EXAMINATION FEES AND CO-PAYMENTS ARE COLLECTED AT THE TIME SERVICE IS RENDERED. THESE FEES ARE COLLECTED FOR EVERY VISIT.
- PROFESSIONAL EXAMINATION FEES ARE COLLECTED SEPARATE FROM THE PURCHASE OF ANY EYEWEAR.
- DISCOUNTS AND PROMOTIONAL COUPONS ARE NOT ACCEPTED IN CONJUNCTION WITH ANY OTHER DISCOUNT, COUPON, INSURANCE BENEFIT OR THIRD PARTY PROGRAM.
- ACCOUNT ADJUSTMENTS AND CREDITS WILL NOT BE PROVIDED AT A LATER DATE.
- A \$ 20.00 ADMINISTRATIVE FEE WILL BE CHARGED ON ALL RETURNED CHECKS.

PATIENT MEDICAL HISTORY

| PURPOSE OF YOUR VISIT | REVIEW OF SYSTEMS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> ANNUAL EXAMINATION <input type="checkbox"/> EYE HEALTH EVALUATION <input type="checkbox"/> PRE OR POST OPERATIVE CARE <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER: _____ | INDICATE IF YOU OR ANY BLOOD RELATIVES HAVE ANY OF THE FOLLOWING: <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 5%;"></th> <th style="width: 7.5%;">YOU</th> <th style="width: 7.5%;">RELATIVE</th> </tr> </thead> <tbody> <tr><td>ALLERGIES</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ASTHMA / BRONCHITIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>BREATHING PROBLEMS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>ARTHRITIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>AUTO-IMMUNE DEFICIENCY (HIV / AIDS)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>BLOOD / VASCULAR DISORDER (ANEMIA, SICKLE CELL)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>CANCER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>DIABETES</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>FATIGUE</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>GASTROINTESTINAL / DIGESTIVE DISORDERS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEADACHES</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEARING IMPAIRMENT</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEART (CARDIOVASCULAR) DISEASE</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HEPATITIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HIGH BLOOD PRESSURE</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>INFECTION COUGH / FEVER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>HORMONAL / THYROID DISORDER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>MUSCULOSKELETAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>NEUROLOGICAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>PSYCHIATRIC</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>RESPIRATORY</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>SINUS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>SKIN</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>TUBERCULOSIS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>WEAKNESS / NUMBNESS IN ARMS / LEGS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>WEIGHT GAIN / LOSS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>OTHER DISORDERS/DISEASES NOT LISTED</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> | | | YOU | RELATIVE | ALLERGIES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA / BRONCHITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | BREATHING PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AUTO-IMMUNE DEFICIENCY (HIV / AIDS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD / VASCULAR DISORDER (ANEMIA, SICKLE CELL) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CANCER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FATIGUE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | GASTROINTESTINAL / DIGESTIVE DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEADACHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEARING IMPAIRMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEART (CARDIOVASCULAR) DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | INFECTION COUGH / FEVER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HORMONAL / THYROID DISORDER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | MUSCULOSKELETAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NEUROLOGICAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PSYCHIATRIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | RESPIRATORY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | SINUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | SKIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULOSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WEAKNESS / NUMBNESS IN ARMS / LEGS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WEIGHT GAIN / LOSS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OTHER DISORDERS/DISEASES NOT LISTED | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | YOU | RELATIVE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ALLERGIES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ASTHMA / BRONCHITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BREATHING PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AUTO-IMMUNE DEFICIENCY (HIV / AIDS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BLOOD / VASCULAR DISORDER (ANEMIA, SICKLE CELL) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CANCER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FATIGUE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GASTROINTESTINAL / DIGESTIVE DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEADACHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEARING IMPAIRMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEART (CARDIOVASCULAR) DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INFECTION COUGH / FEVER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HORMONAL / THYROID DISORDER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MUSCULOSKELETAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NEUROLOGICAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PSYCHIATRIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RESPIRATORY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SINUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SKIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TUBERCULOSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WEAKNESS / NUMBNESS IN ARMS / LEGS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WEIGHT GAIN / LOSS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER DISORDERS/DISEASES NOT LISTED | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCULAR HISTORY <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 50%;"></th> </tr> </thead> <tbody> <tr> <td>DO YOU CURRENTLY WEAR GLASSES?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HOW LONG? _____</td> </tr> <tr> <td>DO YOU CURRENTLY WEAR CONTACT LENSES?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>BRAND? _____</td> </tr> <tr> <td>HAVE YOU EVER HAD ANY EYE SURGERY?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>TYPE? _____</td> </tr> <tr> <td>HAVE YOU EVER HAD REFRACTIVE SURGERY?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>WHEN? _____</td> </tr> <tr> <td>DO YOU WORK ON A COMPUTER?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td># HOURS PER DAY _____</td> </tr> </tbody> </table> | | YES | NO | | DO YOU CURRENTLY WEAR GLASSES? | <input type="checkbox"/> | <input type="checkbox"/> | HOW LONG? _____ | DO YOU CURRENTLY WEAR CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | BRAND? _____ | HAVE YOU EVER HAD ANY EYE SURGERY? | <input type="checkbox"/> | <input type="checkbox"/> | TYPE? _____ | HAVE YOU EVER HAD REFRACTIVE SURGERY? | <input type="checkbox"/> | <input type="checkbox"/> | WHEN? _____ | DO YOU WORK ON A COMPUTER? | <input type="checkbox"/> | <input type="checkbox"/> | # HOURS PER DAY _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU CURRENTLY WEAR GLASSES? | <input type="checkbox"/> | <input type="checkbox"/> | HOW LONG? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU CURRENTLY WEAR CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | BRAND? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HAVE YOU EVER HAD ANY EYE SURGERY? | <input type="checkbox"/> | <input type="checkbox"/> | TYPE? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HAVE YOU EVER HAD REFRACTIVE SURGERY? | <input type="checkbox"/> | <input type="checkbox"/> | WHEN? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU WORK ON A COMPUTER? | <input type="checkbox"/> | <input type="checkbox"/> | # HOURS PER DAY _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU OR ANY (BLOOD) RELATIVES HAVE ANY OF THE FOLLOWING EYE DISORDERS: <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;">YOU</th> <th style="width: 10%;">RELATIVE</th> <th style="width: 20%;"></th> </tr> </thead> <tbody> <tr><td>CATARACTS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>GLAUCOMA</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>MACULAR DEGENERATION</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>RETINAL DETACHMENT</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>COLOR BLINDNESS</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>CROSSED / TURNED EYES</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>AMBLYOPIA (LAZY EYE)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>OTHER VISION DISORDER</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> </tbody> </table> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 50%;"></th> </tr> </thead> <tbody> <tr> <td>DO YOU SMOKE?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>PACKS PER DAY _____</td> </tr> <tr> <td>DO YOU DRINK ALCOHOL?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>DRINKS PER WEEK _____</td> </tr> <tr> <td>FEMALES - ARE YOU PREGNANT OR NURSING?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table> | | YOU | RELATIVE | | CATARACTS | <input type="checkbox"/> | <input type="checkbox"/> | | GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> | | MACULAR DEGENERATION | <input type="checkbox"/> | <input type="checkbox"/> | | RETINAL DETACHMENT | <input type="checkbox"/> | <input type="checkbox"/> | | COLOR BLINDNESS | <input type="checkbox"/> | <input type="checkbox"/> | | CROSSED / TURNED EYES | <input type="checkbox"/> | <input type="checkbox"/> | | AMBLYOPIA (LAZY EYE) | <input type="checkbox"/> | <input type="checkbox"/> | | OTHER VISION DISORDER | <input type="checkbox"/> | <input type="checkbox"/> | | | YES | NO | | DO YOU SMOKE? | <input type="checkbox"/> | <input type="checkbox"/> | PACKS PER DAY _____ | DO YOU DRINK ALCOHOL? | <input type="checkbox"/> | <input type="checkbox"/> | DRINKS PER WEEK _____ | FEMALES - ARE YOU PREGNANT OR NURSING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YOU | RELATIVE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CATARACTS | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MACULAR DEGENERATION | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RETINAL DETACHMENT | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COLOR BLINDNESS | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CROSSED / TURNED EYES | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AMBLYOPIA (LAZY EYE) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER VISION DISORDER | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU SMOKE? | <input type="checkbox"/> | <input type="checkbox"/> | PACKS PER DAY _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU DRINK ALCOHOL? | <input type="checkbox"/> | <input type="checkbox"/> | DRINKS PER WEEK _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEMALES - ARE YOU PREGNANT OR NURSING? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN AND THE CONDITIONS BEING TREATED (INCLUDE NUTRITIONAL SUPPLEMENT, HERBS AND RECREATIONAL OR OVER THE COUNTER DRUGS) | PLEASE LIST ALL DRUG AND FOOD ALLERGIES (INCLUDING MEDICATIONS, TAPE, LATEX AND DYES) |
|--|---|
| MEDICATION | CONDITION |
| | |
| | |
| | |
| | |
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| | |

ABOUT YOUR EYE EXAMINATION

SEVERAL PROCEDURES ARE REQUIRED TO EXAMINE THE HEALTH OF THE EYE AND OBTAIN TREATMENT AND/OR PRESCRIPTION FOR YOUR EYEWEAR. YOUR COMPREHENSIVE EXAMINATION AND/OR ANY OTHER PROCEDURE GENERALLY REQUIRES THE INSTILLATION OF EYE DROPS TO DILATE THE PUPIL OF THE EYE. DILATING DROPS ALLOW THE DOCTOR TO EXAMINE THE STRUCTURES INSIDE OF THE EYE. THESE DROPS MAY RESULT IN LIGHT SENSITIVITY, HAZY VISION AND DIFFICULTY FOCUSING AT NEAR FOR A DURATION OF FOUR (4) TO SIX (6) HOURS. PLEASE EXERCISE CAUTION WHILE DRIVING, OPERATING EQUIPMENT, OR PERFORMING NEAR POINT TASKS DURING THE DURATION OF THESE EFFECTS.

CONSENT OF DISCLOSURE FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

DURING THE COURSE OF PROVIDING SERVICE TO YOU, WE CREATE, RECEIVE, AND STORE HEALTH INFORMATION THAT IDENTIFIES YOU. YOUR HEALTH AND MEDICAL RECORDS ARE PRIVATE AND CONFIDENTIAL. THIS INFORMATION IS REGUARDED IN A PROFESSIONAL AND CONFIDENTIAL MANNER. IT IS OFTEN NECESSARY TO USE AND DISCLOSE YOUR HEALTH INFORMATION IN ORDER TO TREAT YOU, TO OBTAIN PAYMENT FOR OUR SERVICES, AND TO CONDUCT HEALTH CARE OPERATIONS INVOLVING OUR OFFICE.

THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT PURPOSES NOT ONLY INCLUDES CARE AND SERVICES PROVIDED HERE, BUT ALSO DISCLOSURES OF YOUR HEALTH INFORMATION AS MAY BE NECESSARY FOR YOU TO RECEIVE FOLLOW-UP CARE FROM US OR ANOTHER HEALTH PROFESSIONAL. THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION FOR THE PURPOSES OF PAYMENT INCLUDES, BUT IS NOT LIMITED TO, THE SUBMISSION OF THIS INFORMATION TO A BILLING AGENT OR VENDOR FOR DETERMINATION OF BENEFITS, PROCESSING CLAIMS AND RECEIVING PAYMENT.

WHEN YOU SIGN THIS CONSENT DOCUMENT, YOU AGREE AND ACKNOWLEDGE THAT WE MAY DISCLOSE YOUR HEALTH INFORMATION TO TREAT YOU, OBTAIN PAYMENT FOR OUR SERVICES, AND TO PERFORM HEALTH CARE OPERATIONS. YOU AUTHORIZE THE SUBMISSION OF HEALTH INFORMATION TO THIRD PARTY ORGANIZATIONS NECESSARY TO PROCESS CLAIMS AND RECEIVE PAYMENT FOR SERVICES PROVIDED. YOU ACKNOWLEDGE THAT SUPPORT PERSONNEL EMPLOYED BY FRUTCHEY EYE CARE, P.A. OR OTHER APPOINTED AGENCIES WILL HAVE ACCESS TO YOUR HEALTH INFORMATION. YOU AUTHORIZE THE PAYMENT OF MEDICAL INSURANCE BENEFITS TO FRUTCHEY EYE CARE, P.A. OR OTHER APPOINTED AGENCIES OR PARTIES WHO MAY ACCEPT ASSIGNMENT FOR SERVICES PROVIDED.

YOU ACKNOWLEDGE THE IMPORTANCE OF DILATING DROPS, AS WELL AS, UNDERSTAND THE EFFECTS ON YOUR VISION AND WISH TO **ACCEPT / DECLINE** THE USE OF DILATING EYE DROPS.

YOU CAN REVOKE THIS CONSENT IN WRITING AT ANY TIME UNLESS WE HAVE ALREADY TREATED YOU, SOUGHT PAYMENT FOR OUR SERVICES, OR PERFORMED HEALTH CARE OPERATIONS IN RELIANCE UPON OUR ABILITY TO USE OR DISCLOSE YOUR HEALTH INFORMATION IN ACCORDANCE WITH THIS CONSENT. WE CAN DECLINE TO SERVICE YOU IF YOU ELECT NOT TO SIGN THIS CONSENT FORM.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND VOLUNTARILY CONSENT TO THE STATEMENTS HEREIN. I CONSENT TO THE USE AND DISCLOSURE OF MY HEATH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

PATIENT'S / GUARDIAN SIGNATURE _____ DATE _____