WELCOME

WHO REFERRED YOU TO OUR PRACTICE?

____ Physician – Name _____
____ Patient – Name _____
____ Insurance Company
____ Newspaper ad- which paper _____
____ Internet
____ Sakowitz Eye Center Website
____ Saw building

FAMILY DR _____

FAMILY DR PHONE # _____

PATIENT NAME _____

Address _____

_____

City State Zip Code

Home Phone # _____

Cell Phone # _____

Email address (optional) _____

Employer _____

Business Phone # _____

Spouse Name _____

Spouse Employer _____

Spouse Work # _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

NAME _____

RELATIONSHIP _____

PHONE # _____

Revised Oct 2013

TODAY'S DATE _____

SOCIAL SEC # _____

BIRTHDATE _____

INSURANCE INFORMATION

Primary Insurance Company

_____

Secondary or Supplement Insurance Company

_____

PLEASE BRING
YOUR INSURANCE CARDS
TO THE OFFICE

Ethnic Background –circle one

Hispanic or Latino Not Hispanic or Latino
Unknown

Race – circle one

American Indian/Alaska Native	White
Asian Indian or Other	Chinese
Black or African American	Filipino
Native Hawaiian	Pacific Islander
Guamanian	Japanese
Korean	Pacific Islander
Samoan	Vietnamese
Other	Unknown

Preferred Language _____

Pharmacy Information

Pharmacy Name _____

Address _____

Phone # _____

(THIS FORM MUST BE FILLED OUT BY PATIENT PRIOR TO SEEING PHYSICIAN AS PER FEDERAL GUIDELINES)

Name _____ Date _____ Chart_____

YOUR EYE HISTORY

Glaucoma	Yes	No	Cataracts	Yes	No
Retinal problems	Yes	No	Retinal Disease	Yes	No
Macular Degeneration	Yes	No	Diabetic Disease	Yes	No
Crossed Eyes	Yes	No	Corneal Disease	Yes	No
Injury	Yes	No			

Any treatments for eye problems? _____

YOUR SURGICAL HISTORY

DATE

_____

_____

_____

LIST ALL MEDICATIONS YOU TAKE

MEDICATIONS

_____
_____
_____
_____
_____
_____
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_____
_____
_____

MEDICATIONS

_____
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ALLERGIES

Codeine	Yes	No	Environmental	Yes	No
Sulfa	Yes	No	IVP Dye/Iodine	Yes	No
Penicillin	Yes	No	Tape	Yes	No
			Latex	Yes	No

List any others_____

FAMILY HISTORY

Does anyone in your immediate family **(mother, father, brother or sister)** have?

Cancer	Yes	No	Diabetes	Yes	No
Blindness	Yes	No	Heart Disease	Yes	No
Glaucoma	Yes	No	High blood pressure	Yes	No
Retinal problems	Yes	No	Stroke	Yes	No
Macular Degeneration	Yes	No			

YOUR SOCIAL HISTORY

Do you smoke?		Yes	No	Do you drink?	Yes	No
How much_____				How much _____		
Do you drive?		Yes	No	Occupation _____		
Married	Single		Other			

REVIEW OF SYSTEMS

PLEASE FILL IN FORM COMPLETELY (CIRCLE Yes or No)

CARDIOVASCULAR SYSTEM

Chest pain	Yes	No _____
Irreg. Heart rate	Yes	No _____
Stroke	Yes	No _____
Heart Disease	Yes	No _____
Carotid Disease	Yes	No _____
High blood pressure	Yes	No _____
Cholesterol	Yes	No _____
Heart attack	Yes	No _____

SKIN

Acne Rosacea	Yes	No _____
Psoriasis	Yes	No _____

BLOOD

Blood disorders	Yes	No _____
HIV	Yes	No _____

GI (stomach & intestines)

Nausea/Vomiting	Yes	No _____
Blood in stool	Yes	No _____
Ulcers	Yes	No _____

ENDOCRINE

Thyroid disease	Yes	No _____
Diabetes (juvenile)	Yes	No _____
Diabetes (adult)	Yes	No _____
How long?	_____	

RESPIRATORY

Emphysema	Yes	No _____
Sarcoidosis	Yes	No _____
Asthma	Yes	No _____
Shortness of breath	Yes	No _____
Chronic bronchitis or cough	Yes	No _____

CENTRAL NERVOUS SYSTEM

Migraines	Yes	No _____
Stroke	Yes	No _____
Numbness	Yes	No _____
Seizures	Yes	No _____

ONCOLOGY

Cancer	Yes	No _____

EARS/NOSE/THROAT

Hearing loss	Yes	No _____
Sinus problems	Yes	No _____

CONSTITIUTIONAL

Fever	Yes	No _____
Weight loss	Yes	No _____
Chronic fatigue	Yes	No _____

GU (Genitourinary)

Kidney stones	Yes	No _____
Bladder problems	Yes	No _____
Prostate problems	Yes	No _____
Female problems	Yes	No _____
Renal failure	Yes	No _____

MUSCULOSKELETAL

Arthritis	Yes	No _____
Gout	Yes	No _____
Lupus	Yes	No _____
Fibromyalgia	Yes	No _____

PSYCHIATRIC

Anxiety	Yes	No _____
Depression	Yes	No _____

LIST ANY OTHER DISEASE OR ILLNESS NOT MENTIONED ABOVE

_____

_____

Have you ever used Flomax or any other prostate medication? Yes No _____

FLORIDA EYE SURGEONS AND ASSOCIATES

REFRACTIONS

A REFRACTION IS PERFORMED TO DETERMINE IF VISION CAN BE IMPROVED BY A CHANGE IN GLASSES.

REFRACTIONS ARE GENERALLY NOT COVERED BY INSURANCE

PATIENT IS RESPONSIBLE FOR THE $50 FEE
PAYMENT IS DUE AT THE TIME OF SERVICE

REFRACTIONS ARE ROUTINELY PERFORMED:

ANNUAL EXAMS
ROUTINE EXAMS
NEW PATIENT EXAMS

****

IF YOU DO NOT WISH TO HAVE THIS TEST PERFORMED
PLEASE ADVISE THE TECHNICIAN

Signature_____ Date_____

FLORIDA EYE SURGEONS AND ASSOCIATES
2850 WELLNESS AVE
ORANGE CITY, FL 32763
(386) 574-0700

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payors

Conduct normal healthcare operations, such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices and have received a copy of the Patient's Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice Of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name_____

Signature_____

Witness_____

Date_____

FLORIDA EYE SURGEONS AND ASSOCIATES

Florida Eye Surgeons and Associates

Lifetime Authorization Insurance Assignments

and Authorization to Release Information

1. RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or government agency, such as Blue Cross or Medicare), any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

2. PHYSICIAN INSURANCE ASSIGNMENT-I hereby authorize payment directly to any physician examining or treating me for surgical and/or medical benefits otherwise payable to me for their services but not to exceed the reasonable customary charge for these services.

3. MEDICARE/MEDICAID- I certify that the information given by me is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries any information needed for a Medicare/Medicaid claim. I hereby certify all insurance payment shall be assigned to the physician treating me.

4. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. This assignment will remain in effect until revoked by me in writing.

Financial Agreement

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

2. Not all services are covered benefits under all contracts. All non-covered services, such as refractions, are the financial responsibility of the patient.

3. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance company within a reasonable amount of time, not to exceed 60 days.

4. If this account is assigned to an attorney for collection and/or suit or to a collection agency, the prevailing party shall be entitled to reasonable attorney's fees and all costs of collection.

I have read and understand the above Financial Policy

Signature_____Date_____

Florida Eye Surgeons and Associates
2850 Wellness Ave
Orange City, Fl 32738
(386) 574-0700

Patient Authorization to Disclose Information

I give permission to Florida Eye Surgeons and Associates to release any of my personal health information, including any medical information in my chart to:

1.Name_____ Phone Number _____
Relationship to Patient _____

2.Name_____ Phone Number _____
Relationship to Patient _____

3.Name_____ Phone Number _____
Relationship to Patient _____

4.Name_____ Phone Number _____
Relationship to Patient _____

5.Name_____ Phone Number _____
Relationship to Patient _____

6.Name_____ Phone Number _____
Relationship to Patient _____

7.Name_____ Phone Number _____
Relationship to Patient _____

Signature_____ Date_____

Florida Eye Surgeons and Associates
2850 Wellness Ave Orange City, FL 32763
Phone (386) 574-0700 Fax (386) 574-1139

Records Release-HIPAA Compliant

Patient Name:_____

Date of Birth:_____ Social Security #_____

I authorize and request the disclosure of all protected information of the above named individual's health information. I expressly request that the designated record custodian of all covered entities are under HIPAA identified above disclose full and complete protected medical information. I hereby authorize you to release my information including the diagnosis and records of any treatment or examination rendered to me during my treatment period, including visual fields, photos and operative reports.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosure for the purpose of continued ocular medical care:

I understand the following:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to the authorization may be re-disclosed to other parties
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Any facsimile, copy or photography of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date