WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING INFORMATION

PATIENT IDENTIFYING INFORMATION

LAST NAME ☐ MR. ☐ MRS. ☐ MS. ☐ DR.	FIRST NAME	MIDDLE NAME	TODAY'S DATE

HOME ADDRESS			
CITY		STATE	ZIP
HOME TELEPHONE	OFFICE TELEPHONE	MOBILE TELEPHONE	EMAIL ADDRESS
( )	( )	( )	

SEX ☐ FEMALE ☐ MALE	BIRTH DATE	AGE	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	LIST FAMILY MEMBERS WHO ARE PATIENTS AT THIS OFFICE

EMPLOYER / (SCHOOL)	OCCUPATION / (GRADE)		

HOW DID YOU HEAR ABOUT OUR OFFICE ☐ INSURANCE ☐ PHONE BOOK ☐ PREVIOUS PATIENT / ALTAMONTE ☐ NEWSPAPER AD ☐ LOCATION ☐ PREVIOUS PATIENT / SANFORD	REFERRED BY ☐ FRIEND ☐ PRIMARY CARE DOCTOR	NAME OF PERSON WHO REFERRED YOU

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

- ☐ ANNUAL EXAMINATION
- ☐ EYE HEALTH EVALUATION
- ☐ PRE OR POST OPERATIVE CARE
- ☐ EMERGENCY
- ☐ OTHER: _____
- ☐ CONTACT LENS FITTING
- ☐ REFRACTIVE SURGERY CONSULTATION
- ☐ DIABETIC EYE EXAMINATION
- ☐ GLAUCOMA EXAMINATION

OCULAR HISTORY

	YES	NO	
DO YOU CURRENTLY WEAR GLASSES?	☐	☐	HOW LONG? _____
DO YOU CURRENTLY WEAR CONTACT LENSES?	☐	☐	BRAND? _____
HAVE YOU EVER HAD ANY EYE SURGERY?	☐	☐	TYPE? _____
HAVE YOU EVER HAD REFRACTIVE SURGERY?	☐	☐	WHEN? _____
DO YOU WORK ON A COMPUTER?	☐	☐	# HOURS PER DAY_____

DO YOU OR ANY (BLOOD) RELATIVES HAVE ANY OF THE FOLLOWING EYE DISORDERS:

	YOU	RELATIVE
CATARACTS	☐	☐
GLAUCOMA	☐	☐
MACULAR DEGENERATION	☐	☐
RETINAL DETACHMENT	☐	☐
COLOR BLINDNESS	☐	☐
CROSSED / TURNED EYES	☐	☐
AMBLYOPIA (LAZY EYE)	☐	☐
OTHER VISION DISORDER	☐	☐

	YES	NO	
DO YOU SMOKE?	☐	☐	PACKS PER DAY _____
DO YOU DRINK ALCOHOL?	☐	☐	DRINKS PER WEEK _____
FEMALES - ARE YOU PREGNANT OR NURSING?	☐	☐	

REVIEW OF SYSTEMS:

INDICATE IF YOU OR ANY BLOOD RELATIVES HAVE ANY OF THE FOLLOWING:

	YOU	RELATIVE
ALLERGIES	☐	☐
ASTHMA / BRONCHITIS	☐	☐
BREATHING PROBLEMS	☐	☐
ARTHRITIS	☐	☐
AUTO-IMMUNE DEFICIENCY (HIV / AIDS)	☐	☐
BLOOD / VASCULAR DISORDER (ANEMIA, SICKLE CELL)	☐	☐
CANCER	☐	☐
DIABETES	☐	☐
FATIGUE	☐	☐
GASTROINTESTINAL / DIGESTIVE DISORDERS	☐	☐
HEADACHES	☐	☐
HEARING IMPAIRMENT	☐	☐
HEART (CARDIOVASCULAR) DISEASE	☐	☐
HEPATITIS	☐	☐
HIGH BLOOD PRESSURE	☐	☐
INFECTION COUGH / FEVER	☐	☐
HORMONAL / THYROID DISORDER	☐	☐
MUSCULOSKELETAL	☐	☐
NEUROLOGICAL	☐	☐
PSYCHIATRIC	☐	☐
RESPIRATORY	☐	☐
SINUS	☐	☐
SKIN	☐	☐
TUBERCULOSIS	☐	☐
WEAKNESS / NUMBNESS IN ARMS / LEGS	☐	☐
WEIGHT GAIN / LOSS	☐	☐
OTHER DISORDERS/DISEASES NOT LISTED	☐	☐
_____	☐	☐

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN AND THE CONDITIONS BEING TREATED (INCLUDE NUTRITIONAL SUPPLEMENT, HERBS AND RECREATIONAL OR OVER THE COUNTER DRUGS)

MEDICATION	CONDITION

PLEASE LIST ALL DRUG AND FOOD ALLERGIES (INCLUDING MEDICATIONS, TAPE, LATEX AND DYES)

ALLERGIES

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 _____