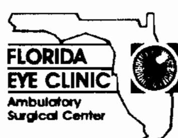


FEC Record #________________

FLORIDA EYE CLINIC - MEDICAL/SOCIAL HISTORY

PLEASE BRING THIS FORM WITH YOU THE DAY OF YOUR APPOINTMENT

Date ________________ Patient's Name ________________

If Child: Mother's Name ________________ Father's Name ________________

WHAT IS YOUR MARITAL STATUS? ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation ________________

PLEASE CHECK "YES" OR "NO" FOR THE FOLLOWING

1.	Social Drug Use?	☐ YES	☐ NO			
2.	Alcohol?	☐ YES	☐ NO	DRINKS/DAY		
3.	Tobacco Use	☐ YES	☐ NO	PACKS/DAY		
4.	Diabetes	☐ YES	☐ NO	HOW LONG?	MEDICATION	
5.	High Blood Pressure	☐ YES	☐ NO	HOW LONG?	MEDICATION	
6.	Heart Disease	☐ YES	☐ NO	HOW LONG?	MEDICATION	
7.	Cancer	☐ YES	☐ NO	HOW LONG?	MEDICATION	
8.	Arthritis	☐ YES	☐ NO	HOW LONG?	MEDICATION	
9.	Lung Disease	☐ YES	☐ NO	HOW LONG?	MEDICATION	
10.	Glaucoma	☐ YES	☐ NO	HOW LONG?	MEDICATION	
				HAVE SURGERY?	WHICH EYE?	WHEN?
11.	Cataracts	☐ YES	☐ NO	HOW LONG?	SURGERY?	WHEN?
				INTRAOCULAR LENS IMPLANT		
12.	Do you wear contacts?	☐ YES	☐ NO	HOW LONG?	HARD SOFT	EXT. WEAR
13.	Have Lazy Eye (Amblyopia)	☐ YES	☐ NO	HOW LONG?	WHICH EYE?	

Is there a family history of any of the above diseases? ☐ YES ☐ NO Which disease? ________________

List any other medical conditions you have ________________

What other medicines do you take? ________________

To what MEDICINES are you ALLERGIC? ☐ Penicillin ☐ Sulfa ☐ Steroids ☐ Aspirin ☐ Codeine
☐ Other (list them) ________________

Are you ALLERGIC to any EYE DROPS? ☐ YES ☐ NO IF YES, IDENTIFY ________________

Have you ever had an eye examination? ☐ Ophthalmologist ☐ Optometrist
☐ Other Date of last exam: ________ Name/address of examiner ________________

Do you use eye drops? ☐ YES ☐ NO Please list ________________

When was your last change in eyeglasses? ________________

Have you ever been hit in the eye? YES ☐ NO When? ________ Which Eye? ________

What eye surgery have you had? ________________

Are you, or have you ever been cross-eyed? ________________

WHAT IS THE MAIN PROBLEM YOU ARE PRESENTLY HAVING WITH YOUR EYES? ________________

Are you interested in surgery to reduce your need for glasses? ☐ YES ☐ NO

I understand that many examinations will require dilation of the pupil of the eyes which may make my driving vision blurry and light sensitive and my transportation is my responsibility.

Signature ________________

INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATION TO CHILDREN

I give permission for eye medication to be administered to my son/daughter. I understand that these medications are for the purpose of his/her diagnosis and treatment.

I realize that in the course of this diagnosis and treatment, my child may need to be restrained by being held during the administration of drops or examination. In that event, I understand that I'm responsible for the restraint and holding of my child.

Signature ________________

Patient's Name ______________________ Chart # ______________

SPECIAL PROCEDURE / SURGERY / PROBLEM LIST

OFFICE USE ONLY			
DATE	DOCTOR	SURGERY / PROCEDURE / DIAGNOSIS	POST OPERATIVE PERIOD

SUMMARY OF PRIVACY PRACTICE

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- To run our Practice more efficiently and ensure all our patients receive quality care
- For appointments and patient recall reminders
- For research
- To avert a serious threat to health or safety
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

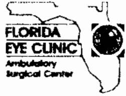
- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices.

Signed by: ______________________ Relationship (*if other than patient*) ______________

Printed Name of Patient or Representative ______________________ Date: ______________

OFFICE USE ONLY			
MEDICAL INFORMATION DISCLOSURE LOG			
DATE	RECORDS REQUESTED	SENT TO	FEC STAFF SIGNATURE



FLORIDA EYE CLINIC - ACCOUNT INFORMATION (Please Print)

CHART # ____________________ DATE ____________ DR'S NAME ____________________

PATIENT NAME ____
LAST FIRST MI

SEX ________ BIRTHDATE ____________ AGE ________ PATIENT'S SOC. SEC. # ____________________

HOME PHONE (___) ______________ WORK PHONE (___) ______________ CELL PHONE (___) ______________

ADDRESS ____
STREET CITY STATE ZIP

EMPLOYER ______________________ ADDRESS ______________________

EMERGENCY CONTACT: *(OTHER THAN HOME TELEPHONE NUMBER)*

NAME ______________________ PHONE (____) ______________ RELATIONSHIP ______________

REFERRED BY: DR. / OTHER ______________________________ CITY ______________

PRIMARY CARE PHYSICIAN: ______________________________ CITY ______________

NAME AND ADDRESS OF RESPONSIBLE PARTY ______________________________________

PRIMARY INSURANCE ______________________ **SECONDARY INSURANCE** ______________________

POLICY HOLDER ______________________ POLICY HOLDER ______________________

POLICY HOLDERS'S SOC. SEC. # ______________________ POLICY HOLDER'S SOC. SEC. # ______________________

POLICY HODER'S DATE OF BIRTH ______________________ POLICY HOLDER'S DATE OF BIRTH ______________________

WHAT RELATIONSHIP ARE YOU TO THE POLICY HOLDER? ______________________________

COPY OF PRIMARY CARD (FRONT & BACK) COPY OF SECONDARY CARD (FRONT & BACK)

OFFICE USE ONLY

PATIENT NAME ____

LIFETIME INSURANCE ASSIGNMENT

A. In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient (including but not limited to private and group health, automobile liability, general liability, personal injury protection, medical payments, and uninsured or underinsured motor vehicle benefits) such benefits or recovery are hereby assigned directly to Florida Eye Clinic "FEC" for application to the patient's bill, and I authorize payment to FEC of such benefits or recovery. It is agreed that FEC may receipt for any such payment. I am responsible for charges not covered by this assignment.

B. I hereby assign the insurance benefits otherwise payable to the undersigned and/or patient to any involved physician(s), and I authorize direct payment to said physicians of such benefits. I am responsible for charges not covered by this assignment.

C. Section 817.234, Florida Statutes, stipulates that "any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree."

2. ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. (Medicare Patients Only)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient 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 payment of authorized benefits be made on the patient's behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered charges, including personal charges.

3. PATIENT/GUARANTOR AGREEMENT.

A As used in the Agreement, "non-covered charges" mean that are not covered by a third party for any reason, including, but not limited to, denial of coverage, exclusion from coverage, and absence of a responsible third party payor. However, "non-covered charges" do not include the difference between FEC's charges and rates that have been established by contract, if any between FEC and the responsible third party payor(s).

B. Whether I sign as agent/representative or patient, in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay and unconditionally guarantee payment to FEC of patient's co-payments, deductibles and non-covered charges, in accordance with the regular rates and terms of FEC, or such other rates and terms as are applicable to patient's account(s) by contract or regulation. Should any portion of the patient's account(s) be referred to any attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees, whether or not suit is filed.

C. I agree to pay FEC at TIME OF SERVICE all co-payments, deductibles, and non-covered charges. I agree that if FEC has been unable to verify patient's coverage, I will pay the entire estimated charges.

I certify I have read the foregoing. I certify I am the patient, or that I am duly authorized as the patient's agent or representative to execute the above and accepts its items.

Signature:____________________________

Note: The refractive portion of your exam is not reimbursable (paid) by medical insurance. This fee is your responsibility and will be collected at the time of service.

Initials:__________

MONTHLY ATTESTATION STATEMENT

By signing I confirm the insurance & personal information listed on the front of this form is accurate.

DATE	INSURANCE *(List all)*	SIGNATURE	FEC INITIALS