Welcome (Print the answers to all questions. Your information will remain confidential per HIPAA policy)

Name: _____ **Nickname:** _____

If minor, PARENT/GUARDIAN name: _____

Street Address: _____ **Apt** _____ **City** _____ **State** _____ **Zip** _____

Cell Phone: _____ **Home Phone:** _____ **Email address:** _____

Date of Birth: _____ **Sex:** ❑ Male ❑ Female **SSN:** _____

Occupation (or Grade): _____ **Employer (or School):** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Who may we thank for telling you about our office? ❑ Insurance website ❑ Internet Search ❑ Previous Patient
❑ Walk By/Signage ❑ Referral from Friend or Family Member _____

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Other

Preferred Language: ❑ English ❑ Other: _____

The name of your Medical Doctor is: _____ **Phone:** _____

AUTHORIZED USERS TO PATIENT'S RECORDS (EMERGENCY CONTACT):

Name: _____ **Phone:**_____ **Relationship to Patient:** _____

Name: _____ **Phone:**_____ **Relationship to Patient:** _____

Checking the Health of Your Eyes

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will study the internal structures of your eye to ensure proper health. The drops administered will cause light sensitivity and some degree of blurred vision, especially near vision (effects can last up to 5 hours). Driving may be affected and should be done with extreme caution. Because your safety is of utmost importance to us, we prefer that you have someone with you to drive.

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Duval Eye Associates, to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Duval Eye Associates directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Acknowledgment of Privacy and Voluntary Consent Form

I have read this Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

_____

Signature

Personal Eye History

What is the reason for your visit today? Glasses / Contacts / Both / Other: _____

Do you have any of the following problems?

❑ Eye Pain or Soreness ❑ Infection of Eye or Lid
❑ Loss of Vision ❑ Blurred Vision ❑ Halos ❑ Redness
❑ Double Vision ❑ Dryness ❑ Mucous Discharge ❑ Floaters
❑ Sandy/Gritty Feeling ❑ Itching ❑ Burning ❑ Flashes
❑ Excess Tearing/Watering ❑ Glare/Light Sensitivity ❑ Tired Eyes
❑ Sties or Chalazion ❑ Foreign Body Sensation ❑ Other _____

When was your last exam? (Approximately) _____ **Doctor's Name/Location:** _____

Do you have any ocular diseases or disorders? ❑ None ❑ Dry Eyes ❑ Cataract ❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Disorder ❑ Amblyopia ❑ Crossed Eye ❑ Trauma ❑ Other _____

Have you had any eye surgeries? ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Eyelid ❑ Other _____

Do you wear GLASSES? ❑ No ❑ Yes **When do you wear your GLASSES?** ❑ Full time ❑ Part time
Do you wear CONTACTS? ❑ No ❑ Yes

If you know the Brand of your contacts, please indicate: _____

Personal Medical History (Many general medical conditions affect the eye and your vision)

❑ Please check this box if you DO NOT have any medical conditions.

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional ❑ **None** ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer ❑ Other _____	**Neurological** ❑ **None** ❑ Multiple sclerosis ❑ Epilepsy/Seizures ❑ Headaches ❑ Other _____	**Gastrointestinal** ❑ **None** ❑ Crohn's disease ❑ Colitis ❑ Ulcer ❑ Digestive concern ❑ Other _____
Allergic/Immunologic ❑ **None** ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid arthritis ❑ Lupus ❑ Other _____	**Endocrine** ❑ **None** ❑ Type 1 Diabetes ❑ Thyroid Dysfunction ❑ Type 2 Diabetes ❑ Hormonal Dysfunction ❑ Other _____	**Musculoskeletal** ❑ **None** ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis
Cardiovascular ❑ **None** ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure/HTN ❑ High cholesterol	**Blood/Lymphatic** ❑ **None** ❑ Anemia ❑ Leukemia ❑ Other _____	**Integumentary/Skin** ❑ **None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Other_____
Genitourinary ❑ **None** ❑ Urinary tract infections ❑ Kidney concerns ❑ Herpes ❑ Chlamydia ❑ HIV ❑ Other _____	**Psychiatric** ❑ **None** ❑ Depression ❑ Panic Disorder ❑ Schizophrenia ❑ Other _____	**Respiratory** ❑ **None** ❑ Asthma ❑ Bronchitis ❑ Emphysem ❑ Upper respiratory tract infection ❑ COPD ❑ Other _____
Ears, Nose & Throat ❑ **None** ❑ Sinus Problem ❑ Dry Throat/Mouth	*List other medical conditions not mentioned here:*	

Medication History

Do you take any prescription or non-prescription medicines regularly? ❑ no ❑ yes If yes, please list all medicines:

_____

_____

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None
❑ Blindness _____
❑ Cataracts _____
❑ Glaucoma _____
❑ Macular _____
❑ Retinal _____
❑ Corneal disease _____
❑ Lazy Eye _____
❑ Diabetes _____
❑ Heart Disease _____
❑ Hereditary Disease _____
❑ Other Eye Disorders _____

Social History

Use tobacco? ❑ No ❑ Yes **Alcoholic Beverages?** ❑ No ❑ Yes **Illegal Drugs?** ❑ No ❑ Yes
Are you pregnant? ❑ No ❑ Yes **Breast feeding?** ❑ No ❑ Yes

Vision Insurance vs. Medical Insurance

To avoid confusion and misunderstanding, please read the following

We are required by law to follow proper coding and billing guidelines for eye examinations. Your medical insurance will not pay for vision problems and your vision plan will not pay for medical problems. This can **NOT** be determined until the completion of the examination.

Your vision plan provides you with a "well vision" examination. This assumes healthy eyes that only suffer from focusing problems like nearsightedness, farsightedness, astigmatism and presbyopia.

YOUR VISION PLAN WILL ONLY PAY FOR THE EXAM IF THERE IS NOTHING WRONG WITH THE HEALTH OF YOUR EYES.

Dry eyes, red eyes, blepharitis, allergies, contact lens complications, cataract, floaters, optic nerve disorders, retinal problems and diabetes are coded and billed medically.

Professional Service Policies

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. **NO** prescriptions will be given until full patient balance is met. There are **NO REFUNDS** for professional service (eye exams, contact lens exam or medical visits) rendered unless a third party (such as an insurance company) is involved and they request it on your behalf.

We would also like to take this opportunity to familiarize you with our policies in regards to appointments and follow-up appointments. Appointments have priority over Walk-Ins. Walk-Ins are available only if time permits. Appointments have a 10 minute grace period; afterwards they are considered a walk-in.

Please read and understand the following about **Glasses Prescription Rechecks/Follow-ups**:

If follow-up is within 60 days of finalized prescription there is no charge

1) After 60 days of finalized prescription there is a $50 fee (Patient must bring glasses to exam)
2) After 4 months patient must pay for a new full exam.

Our Contact lens follow up visits are intended to assess the quality of each patient's vision with the new contact lenses. We also determine if the patient is experiencing any adverse physiological changes secondary to wearing new contact lenses. These follow-up exams are usually scheduled within 1 to 2 weeks (depending on the type of contact lens) of dispensing the contacts. It is recommended to return with the contacts on unless they are causing a problem that makes wearing them too uncomfortable or not healthy for the eye.

Please read and understand the following about **Contact lens follow-up:**

1) Contact lens follow ups are ABSOLUTELY required unless a final prescription has been released.
2) Contact lens fitting consists of 3 follow ups within a 60 day period of the original complete exam date at no charge.
3) Follow ups after 60 days of the complete exam will have a $50 fee per visit, up to 4 months from complete exam date.
4) After 4 months of complete exam, patient must pay for a new complete exam in order to finalize their contact lens prescription.

5) **Contact Lens Returns:**
    a. If you wish to exchange or return contact lenses, please return them within 30 days of your receipt of the product. ONLY unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

I acknowledge that I have read and/or received a copy of Duval Eye Associates Professional Service Policies above and the Notice of Privacy Practices posted in our office.

Print Name_____ Signature_____ Date_____

(Patient or Guardian) (Patient or Guardian)