Name: ______________________________

Date: ____________________ DOB: ____________________ rev 06/17/2014

PATIENT MEDICAL HISTORY

Ht: ________ **Wt:** __________ **RACIAL ORIGIN** **Page: 1**

☐ White ☐ Black ☐ Hispanic ☐ Other:

Do you smoke or use tobacco products? ☐ YES ☐ NO
Quantity? ____________ how many years ________ I quit ☐

Do you drink alcoholic beverages? ☐ YES ☐ NO Quantity? __________

Do you use recreational drugs? ☐ YES ☐ NO

Do you have bleeding tendencies? ☐ YES ☐ NO

Do you have dentures? ☐ YES ☐ NO

Loose/missing/broken teeth? ☐ YES ☐ NO

CHECK ALL CONDITIONS YOU HAVE HAD OR ARE BEING TREATED FOR

☐ High blood pressure	☐ Macular degeneration	☐ Prostate problem	☐ Ulcer
☐ Mitral valve prolapse	☐ Colon polyps	☐ Cirrhosis	☐ Reflux
☐ Stroke/TIA	☐ High cholesterol	☐ Cancer	☐ Hepatitis
☐ Paralysis	☐ Heart attack	☐ Endocarditis	☐ HIV+/AIDS
☐ Asthma	☐ Pacemaker/defibrillator	☐ Congestive Heart Failure	☐ Rectal bleed
☐ Shortness of breath	☐ Seizures	☐ Chest pain	☐ Currently pregnant
☐ Thyroid disease	☐ Emphysema	☐ Irregular beat	☐ Kidney stones
☐ Renal disease	☐ Tuberculosis	☐ Alzheimer's	☐ Hypoglycemia
☐ Sleep apnea	☐ Diabetes	☐ Tremors	☐ Arthritis
☐ Anemia	☐ Hiatal hernia	☐ COPD	☐ Renal failure/dialysis

OTHER:

Have you or any immediate family member experienced any anesthesia complications?

☐ **YES** ☐ **NO** Explain:

INDICATE ALL PREVIOUS SURGERIES

☐ Heart bypass _____ vessels	☐ Heart valve replacement
☐ Pacemaker/defibrillator	☐ Heart stents x _________
☐ Abdominal aortic aneurysm	☐ Carotid endarterectomy ☐ Left ☐ Right
☐ Spleenectomy	☐ Brain surgery
☐ Lung resection ☐ Left ☐ Right	☐ Organ transplant
☐ Cervical laminectomy/fusion	☐ Lumbar laminectomy/fusion
☐ Total hip replacement ☐ Left ☐ Right	☐ Total knee replacement ☐ Left ☐ Right
☐ Colon resection	☐ Rotator cuff repair ☐ Left ☐ Right
☐ Hysterectomy	☐ Prostatectomy
☐ Mastectomy ☐ Left ☐ Right	☐ Appendectomy
☐ Gallbladder	☐ Hernia repair ☐ Left ☐ Right
☐ Cataract removal	☐ Cesarean section
☐ Other: ____________________	☐ Tonsillectomy

Family History: Do any medical problems run in your family?

☐ No ☐ diabetes ☐ high blood pressure ☐ glaucoma ☐ macular degeneration ☐ other

Do you have and Advanced Directive or Living Will? ☐ **yes** ☐ **no**

Review of Systems: Do you have any of the following symptoms? ☐ **No**

_______ neurological problems (headaches, paralysis, numbness) ____________

_______ psychiatric problems (depression, anxiety, etc.) ____________

_______ chronic fever, unexplained weight loss / gain, fatigue ____________

_______ ear / nose / throat problems (hearing loss, sinus problems) ____________

_______ heart problems (chest pain, irregular heart beat) ____________

_______ respiratory problems (wheezing, shortness of breath) ____________

_______ urinary problems (pain, blood in urine, etc.) ____________

_______ gatrointestinal problems (diarrhea, vomiting, etc.) ____________

_______ skin problems (rashes, non-healing lesions, etc.) ____________

_______ musculoskeletal problems (joint pain, muscle aches) ____________

Name: ____________________

Date: ____________ DOB: ____________

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MEDICATION LIST AND DOSAGE

Name	Dosage	Frequency	Last Dose	Last Dose	Last Dose
RN confirmed Pt and MD signature :		**Initials**			

Please list all Allergies and Reactions

❑ **No Known Drug Allergies**

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: ____________ Reaction: ____________

Allergy: Reaction:

Reviewed	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	
No Changes	**Patient Signature**	**MD Signature**	**Date**	

Name: ______________________________

Date: ____________________ DOB: ________________ rev1/14/13

CENTER FOR ADVANCED EYE CARE / ADVANCED EYE SURGERY CENTER

Ophthalmology ● Ophthalmic Plastic & Reconstructive Surgery

Patient Privacy Questionnaire and HIPAA Acknowledgement

Name ______________________________

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

May we contact you at home? ❑ yes ❑ no ❑ n/a Home ph ( ) ____________
Is it okay for us to leave a voice message at this number? ❑ yes ❑ no

May we contact you at work? ❑ yes ❑ no ❑ n/a Work ph ( ) ____________ ext. ______
Is it okay for us to leave a voice message at this number? ❑ yes ❑ no

May we contact you via mobile phone? ❑ yes ❑ no ❑ n/a Mobile ph ( ) ____________
Is it okay for us to leave a voice message at this number? ❑ yes ❑ no

Can a message be left with our company name and what the call is in reference to? ❑ yes ❑ no

Is there anyone we may leave a message with? ❑ yes ❑ no If yes, please list first and last names.

____________________ ____________________

____________________ ____________________

Who do you authorize our staff to speak to regarding your medical information? ❑ n/a

____________________ ____________________

____________________ ____________________

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ❑ yes ❑ no ❑ n/a If yes, please list first and last names.

____________________ ____________________

Center for Advanced Eye Care / Advanced Eye Surgery Center has offered me with a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient's Signature ______________________________ Date ____________

Name: ______________________________

Date: ______________ DOB: ______________

Center for Advanced Eye Care / Advanced Eye Surgery Center

3500 US Highway 1

Vero Beach, Florida 32960

Personal Information Form

Please Print Date ______________

Mr./ Mrs./ Miss/ Ms/ Dr Last Name ______________ First Name ______________ MI ______

Date of Birth ______________ Sex ______________ Social Security # ______________

Address ______________ City ______________ ST ______ Zip ______

Is this address: ❑ **Private residence** ❑ **Assisted living facility** ❑ **Skilled nursing facility**

Home Ph ______________ Work Ph ______________ Cell Phone ______________

Employer ______________ Is visit for work related injury? __ Y __ N

Email Address ______________ Occupation ______________

Primary Care Physician ______________ Phone ______________

Referred by ______________ ❑ Friend ❑ Relative ❑ Physician ❑ Newspaper ❑ radio

Responsible Party

Last Name ______________ First Name ______________ MI ______

Address ______________ City ______________ ST ______ Zip ______

Home Ph ______________ Work Ph ______________ Employer ______________

Date of Birth ______________ Sex ❑ male ❑ female Social Security # ______________

Insurance Information

Primary Ins ______________ Policy # ______________ Group # ______________

Name of Insured (policy holder) ______________ Relationship to insured ❑ self ❑ other

Soc Sec # of Insured ______________ Insured's Date of Birth ______________

Secondary Ins ______________ Policy # ______________ Group # ______________

Name of Insured (policy holder) ______________ Relationship to insured ❑ self ❑ other

Soc Sec # of Insured ______________ Insured's Date of Birth ______________

Emergency Contact Information:

Name: ______________ Relationship: ______________

Primary Phone ______________ Secondary Phone ______________

I agree that The Center for Advanced Eye Care may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Release: I certify that the information I have provided is correct. I authorize the release of medical information to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. *Full payment is expected at the time of visit if we do not participate with your insurance.* If you are unsure about your private health insurance policy, and whether we are participation providers, it is the *patient's responsibility* to contact their insurance company prior to arrival for scheduled appointment.

We are firmly committed to your privacy and protection of your information. We use secure measures to protect against the loss, misuse and alteration of data used by us. We do not share, sell, rent or distribute your email and personal information in any way. If you receive an email from us that looks suspicious please contact us. If you wish to unsubscribe, simply reply to our email and request to be removed.

I have read and understand the above information related to insurance billing. rev 08/31/11

Patient's Signature ______________ Date ______________

Name: ____

Date: ____________________ DOB: ____________________

CENTER FOR ADVANCED EYE CARE

Ophthalmology ● Ophthalmic Plastic & Reconstructive Surgery

Financial Policy Notification Form

Thank you for choosing Center for Advanced Eye Care as your eye care provider. We are committed to providing you and your family with the best available care. In our ongoing process to meet your medical needs, our billing department will be available to discuss our fees and policy with you as needed.

We ask that all responsible parties read and sign our financial policy and complete the patient information forms prior to seeing the physician.

Payment for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, it is the policy of Center for Advanced Eye Care to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(Please read and initial each of the following)

_______ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to the contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

_______ 2. Fees for services, which include unpaid balances, deductibles, and co-payments, are due at time of service. The refraction fee of $45.00 is also due at the time of service; insurance companies will no longer pay for the refraction. Returned checks and unpaid balances will be subject to collection placement and collection fees. All returned checks will have a charge of $25.00.

_______ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed for Center for Advanced Eye Care, you recognize an obligation to promptly remit payment to Center for Advanced Eye Care.

At Center for Advanced Eye Care, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (772) 299-1404.

I understand the above information and will be responsible for the patient listed below.

Printed Name of Patient ____

Signature of patient or responsible party ______________________________ Date __________

rev1/28/13