Florida Eye Care Clinic

Patient Information **Today's Date:** _____

Last Name: _____ First Name: _____ MI: _____ Sex: M F

Birth Date: _____ Social Security#: _____

Address _____ City _____ State _____ Zip _____

Home Ph. ( ) _____ Work Ph. ( ) _____ Cell Ph. ( ) _____

E-mail _____ Occupation _____

Spouse _____ Parent/Guardian _____

How did you learn about our office? **Newspaper Previous Patient Walk in Insurance Co. My Physician Internet Other**

Referred by another patient: Patient's Name _____

Reason for this visit: **Comprehensive Eye Exam Comprehensive Exam for Contacts Eye Infection Eye Injury**

Last Eye Doctor: _____ Last Eye Exam: _____

Current Medical Dr.: _____ Last Medical Exam: _____

Medical History

Are you pregnant and/or nursing? **Yes No**

Do you have any allergies to medications? **Yes No** If yes please explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies) _____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: **Reading Difficulty Crossed Eyes Glaucoma Macular Degeneration**
Lazy Eye Cataracts Retinal Disease Eye Injury

Family History

Have any of your relatives, living or deceased, had any of these conditions?				**Relationship to You**
Blindness	**Yes**	**No**	**Not Sure**	_____
Cataract	**Yes**	**No**	**Not Sure**	_____
Crossed Eyes	**Yes**	**No**	**Not Sure**	_____
Glaucoma	**Yes**	**No**	**Not Sure**	_____
Macular Degeneration	**Yes**	**No**	**Not Sure**	_____
Retinal Detachment/Disease	**Yes**	**No**	**Not Sure**	_____
Arthritis	**Yes**	**No**	**Not Sure**	_____
Cancer	**Yes**	**No**	**Not Sure**	_____
Diabetes	**Yes**	**No**	**Not Sure**	_____
Heart Disease	**Yes**	**No**	**Not Sure**	_____
High Blood Pressure	**Yes**	**No**	**Not Sure**	_____
Kidney Disease	**Yes**	**No**	**Not Sure**	_____
Lupus	**Yes**	**No**	**Not Sure**	_____
Thyroid Disease	**Yes**	**No**	**Not Sure**	_____

Review of Systems

Do you currently or have you ever had any problems in the following areas:

	YES	NO		YES	NO
Cancer			**Ears Nose and Throat**		
Constitutional			Allergies / Hay Fever		
Fever, Weight Loss/ Gain			Sinus Congestion		
Neurological			Post – Nasal Drip		
Headaches			Chronic Cough		
Migraines			Dry Throat / Mouth		
Seizures			**Respiratory**		
Eyes			Asthma		
Loss of Vision			Chronic Bronchitis		
Blurred Vision			Emphysema		
Distorted Vision / Halos			**Vascular / Cardiovascular**		
Loss of Side Vision			Diabetes		
Double Vision			Heart Pain		
Dryness			High Blood Pressure		
Mucous Discharge			Vascular Disease		
Redness			Brain Injury / Stroke		
Sandy or Gritty Feeling			**Gastrointestinal**		
Itching			Diarrhea		
Burning			Constipation		
Foreign Body Sensation			**Genitourinary**		
Excess Tearing / Watering			Genitals / Kidney / Bladder		
Glare / Light Sensitivity			**Bones / Joints / Muscles**		
Eye Pain or Soreness			Rheumatoid Arthritis		
Chronic Infection of Eye or Lid			Muscle Pain		
Sty or Chalazion			Joint Pain		
Flashes / Floaters in Vision			**Lymphatic / Hematologic**		
Tired Eyes			Anemia		
Endocrine			Bleeding Problems		
Thyroid / Other Glands			**Allergic / Immunologic**		
Psychiatric					

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

I would prefer to discuss my Social History information directly with my doctor. **Yes** **No**

Do you drive? **Yes** **No** If yes, do you have visual difficulty when driving? **Yes** **No**

If yes, please describe: _____

Do you use tobacco products? **Yes No** If yes, type/amount/how long: _____

Do you drink alcohol? **Yes No** If yes, type/amount/how long: _____

Do you use recreational drugs? **Yes No** If yes, type/amount/how long?_____

Have you ever been exposed to or infected with:

Gonorrhea **Hepatitis** **HIV** **Syphilis**

Herpes **No, I have not**

_____

Physicians Signature

INSURANCE & FINANCIAL INFORMATION

IF YOU HAVE MEDICARE OR INSURANCE, PLEASE PRESENT CARDS AT FRONT DESK

Please be informed, the insurance company sometimes requires prior authorization. Payment for services is expected on the day of your visit. For your convenience, we accept cash, checks, and all major credit cards.

MEDICARE PATIENTS: Dr. Crump is a Medicare participating provider and therefore will accept assignment on all covered charges. You will be responsible today for the 20% co-payment, any deductible not met, and any non-covered procedures.

INSURANCE PATIENTS: Dr. Crump participates with a few select companies. If you are enrolled with one of these companies, you will be responsible for the co-payment, any deductible not met, and any non-covered procedures. If your company is not one we participate with, a form will be given to you to submit to your company for processing when applicable.

I understand and agree that, regardless of deductibles and insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and agree to pay all collection and attorney fees, should my account become delinquent. I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Dr. Jay Crump, O.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agents, or my insurance company, any information needed to determine these benefits for benefits payable for related services.

I authorize reports of my evaluation and treatment's to be sent to my physician, health care providers, or hospitals that I have or will identify to you.

Signed: _____ Date: _____

Primary Insurance _____

Name of Primary Insured _____

Primary's Date of Birth _____ Social Security _____

Supplement or Secondary Insurance_____

Name of Insured _____

Date of Birth _____ Social Security _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Jay Crump, OD's Notice of Privacy Practices in regards to the HIPPA (Health Information Patient Privacy Act) policy.

Patient Name: _____

Signature: _____

Date: _____

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Florida Eye Care Clinic to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____Date:_____

Refraction Fees

At Florida Eye Care Clinic we take pride in the relationships we hold with our patients. We do our best to be open and up-front about all charges that may be incurred during your visit here. Due to this, we want to inform you of a routine eye exam fee that would not be covered under a health plan.

The refraction during your eye exam is a test to help determine your unique prescription. This refraction is $35 dollars and is not covered by health insurance.
Please anticipate this charge in the case that:

- You are being seen for a routine eye exam under a vision plan but your diagnosis is not routine.
- You do not have a vision plan but have health insurance.

If you have any questions please let us know.

I have read and understood this notice

Patient Name: _____

Patient Signature: _____

Date: _____