

# WELCOME TO THE OFFICE

PATIENT'S INFORMATION	INSURANCE INFORMATION
<p>NAME: _____            ADDRESS: _____            CITY: _____ State _____ Zip _____            DATE OF BIRTH: ____ / ____ / ____            SSN #: _____ - _____ - _____            OCCUPATION: _____            CELL PHONE #: _____ - _____ - _____            PHONE (OTHER): _____ - _____ - _____            EMAIL: _____</p> <p>Reason for visit: (check all that apply)</p> <p><input type="checkbox"/> Glasses/General Health Exam  <input type="checkbox"/> Contact Lens Exam  <input type="checkbox"/> Lasik Consultation  <input type="checkbox"/> Emergency (specify) _____  <input type="checkbox"/> Other _____</p> <p>How did you hear about us?..</p> <p><input type="checkbox"/> Insurance <input type="checkbox"/> Mailer/Flyer  <input type="checkbox"/> Google/Yelp/Facebook <input type="checkbox"/> Drive By Plaza  <input type="checkbox"/> Referral _____</p>	<p>Vision Insurance _____            Subscriber Name _____            Subscriber ID# _____            Subscriber SSN# _____            Subscriber Birthdate ____ / ____ / ____</p> <p style="text-align: center;"><u>Many Medical Insurances will cover eye examinations as well! Please enter your information below so we can determine your coverage.</u></p> <p>Medical Insurance _____            Subscribers Name _____            Subscriber ID# _____            Subscriber SSN# _____            Subscriber Birthdate ____ / ____ / ____</p> <p style="text-align: center;">How will you settle your account today?  <input type="checkbox"/> Cash <input type="checkbox"/> Credit/Debit Card <input type="checkbox"/> CareCredit <input type="checkbox"/> HSA</p> <p style="text-align: center;">(no personal checks)</p>
CONSENT TO DILATION	HIPAA PRIVACY ACKNOWLEDGEMENT
<p>A dilated eye exam is the portion of the eye exam that evaluates the structures and anatomy within the eye for conditions like <b>glaucoma, cataracts, macular degeneration, diabetic eye disease and retinal detachments</b>. This is accomplished using a series of eye drops. Common side effects include blurred vision for several hours, light sensitivity and redness.</p> <p><input type="checkbox"/> <b>YES</b>- I understand the purpose of Dilation and agree to have it performed.</p> <p><input type="checkbox"/> <b>CAMERA</b>- I would prefer a central retinal photograph instead of the dilation. I acknowledge the camera may provide limited testing in comparison to dilated exam. This option may not be available to all patients. As an elective test, Patient will be responsible for all copays.</p> <p><input type="checkbox"/> <b>NO</b>- I understand the purpose of Dilation but choose <u>neither</u> to be dilated <u>nor</u> do I want a retinal photograph. (You may return for another appointment) <i>Florida law requires a dilated eye exam at initial visit unless declined by patient. If declined, Pt releases Greenlake Eyecare of any liability for possible eye disorders that may go undetected without examination.</i></p>	<p>Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your protected health information.</p> <p>We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provision effective for all protected health information that we maintain. In the event that we make a material revision to the term of our notice, you will receive a revised notice. If you should have any questions, please contact our Privacy Officer at *****</p> <p>I am in receipt of notice of privacy practices of Aronson Optometry, PA DBA GreenLake Eyecare.</p> <p>_____/_____/_____            Signature <span style="float: right;">Date</span></p>

## INSURANCE ASSIGNMENT AND RELEASE (SIGN BELOW TO ALLOW US TO FILE YOUR INSURANCE)

Medicare and most medical insurances do not pay for vision examinations or refractions (to determine prescription for glasses.) If a refraction is necessary or requested during the exam, these insurances will disallow it, stating it is a non-covered service. Therefore, the patient will be responsible for the refraction charge. The refraction charge is \$45. If by chance your insurance does pay, we will refund that money to you. The practice of waiving deductible and coinsurance amounts is illegal. I understand I am responsible for these payments.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above companies and assign directly to Aronson Optometry, PA DBA Greenlake Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between myself and my insurance, not Aronson Optometry, PA dba Greenlake Eyecare and I am responsible for all charges whether or not paid by my insurance. If my insurance has not reimbursed this office in full within 90 days, I will be billed the outstanding balance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it agents any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
 Signature of Beneficiary

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

**TURN OVER, PLEASE →**

**PATIENT'S EYE HISTORY**

**Last Eye Exam:** \_\_\_\_\_  
 Doctor: \_\_\_\_\_

Do you wear glasses?     Yes    No  
 All the time  
 Reading Only  
 Distance Only

Do you wear contact lenses?  Yes    No  
 Brand? \_\_\_\_\_  
 Replaced    Daily  
                    1-2 Weeks  
                    Monthly  
                    Gas Permeable/Hard

Are you happy with the vision and comfort of your current contact lenses?  
 Yes    No

Are you **currently** experiencing any of these symptoms?

- Blurry Vision (Far, Computer, or Close)
- Headaches (Daily, Weekly, Other)
- Red Eyes (started \_\_\_\_\_ days/wks/months/ysrs)
- Burning (started \_\_\_\_\_ days/wks/months/ysrs)
- Itching (started \_\_\_\_\_ days/wks/months/ysrs)
- Tearing (started \_\_\_\_\_ days/wks/months/ysrs)
- Discharge (started \_\_\_\_\_ days/wks/months/ysrs)
- Double Vision (started \_\_\_\_\_ days/wks/months/ysrs)
- Flashes of Light (started \_\_\_\_\_ days/wks/months/ysrs)
- Seeing Spots (started \_\_\_\_\_ days/wks/months/ysrs)
- Light Sensitivity (started \_\_\_\_\_ days/wks/months/ysrs)
- Night Problems (started \_\_\_\_\_ days/wks/months/ysrs)
- Total Blindness (started \_\_\_\_\_ days/wks/months/ysrs)
- Other \_\_\_\_\_

Have you **ever** been diagnosed or treated for any of the following?

- Glaucoma
- Cataracts
- Macular Degeneration
- Diabetic Eye Problems
- Eye injury
- Retinal Detachment
- Blindness
- Eye Turn/ Strabismus
- Lazy Eye/Amblyopia
- Dry Eye
- Other \_\_\_\_\_
- Eye Surgery for: \_\_\_\_\_

**PATIENT'S MEDICAL HISTORY**

Primary Care Physician \_\_\_\_\_  
 Telephone # \_\_\_\_\_  
 Last Physical Exam \_\_\_\_\_

**Have you been diagnosed or treated for the following?**

- Diabetes (I or II)
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Stroke
- Cancer (*Breast – Prostate -- Colon – Skin – Lung – Other*)
- Thyroid Disease
- Asthma -- COPD
- Rheumatoid Arthritis
- Depression
- Anxiety
- Attention Deficit Disorder (ADHD)
- Autism
- Lupus
- Currently Pregnant (# of \_\_\_\_\_ Weeks)
- Other \_\_\_\_\_

**No Significant Medical History**

**FAMILY MEDICAL HISTORY**

Does anyone in your family have any of the following conditions?  
**Please list the affected family members.**

	Father	Mother	Brother	Sister
Macular Degeneration				
Blindness				
Glaucoma				
Eye Turn/Strabismus				
Lazy Eye/Amblyopia				
Other Eye Disease				
Cancer				
Diabetes				
High Blood Pressure				
Heart Disease				

**No Remarkable Family History**

**ALL MEDICATIONS**

*(including eye drops)*

*If you have a list, you may provide to the office*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**No Current Medications**

**MEDICATION ALLERGIES**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**No Known Drug Allergies**

**SOCIAL HISTORY**

Alcoholic Beverages

- None
- Rarely
- Socially
- Daily

Smoking

- None – No prior history
- None – Previous Smoker
- 1 pack/day
- 2 packs/day
- 3+ packs/day

**PLEASE RETURN TO FRONT DESK WHEN FINISHED-THANK YOU**