PATIENT'S INFORMATION

NAME: _____
ADDRESS:_____
CITY: _____ STATE _____ ZIP _____
DATE OF BIRTH: _____ / _____ / _____
OCCUPATION:_____
CELL PHONE #: _____-_____-_____
PHONE (OTHER):_____-_____-_____
EMAIL:_____@_____.COM

REASON FOR VISIT: (CHECK ALL THAT APPLY)

- ☐ GENERAL EYE HEALTH EXAM
- ☐ ROUTINE VISION EVALUATION
- ☐ MEDICAL EMERGENCY EXAM
- ☐ CONTACT LENS EVALUATION
- ☐ MYOPIA CONTROL
- ☐ LASIK CONSULTATION
- ☐ OTHER_____

INSURANCE INFORMATION

MEDICAL INSURANCE _____
SUBSCRIBER NAME _____
SUBSCRIBER ID# _____
SUBSCRIBER SSN# _____-_____-_____
SUBSCRIBER BIRTHDAY _____/_____/_____

VISION INSURANCE _____
SUBSCRIBER NAME _____
SUBSCRIBER ID# _____
SUBSCRIBER SSN# _____-_____-_____
SUBSCRIBER BIRTHDAY _____/_____/_____

PATIENTS ARE RESPONSIBLE FOR UNDERSTANDING THEIR COVERAGES.

****0% FINANCING ON ALL ORDERS $250+ WITH CARE CREDIT SERVICES****

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

☐ CHECK HERE IF YOU ARE INTERESTED IN ORTHOKERATOLOGY - (LASIK ALTERNATIVE FOR ALL AGES.)

ARE YOU **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS?

- ☐ BLURRY VISION (FAR, COMPUTER, OR CLOSE)
- ☐ HEADACHES (DAILY, WEEKLY, OTHER)
- ☐ RED EYES (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ BURNING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ ITCHING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ TEARING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ DISCHARGE (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ DOUBLE VISION (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ FLASHES OF LIGHT (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ SEEING SPOTS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ LIGHT SENSITIVITY (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ NIGHT PROBLEMS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ TOTAL BLINDNESS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ 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:
  _____
  _____
  _____
  _____

MEDICAL DRY EYE QUESTIONAIRE

	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
SENSITIVITY TO LIGHTS	4	3	2	1	0
SANDY/GRITTY FEELING	4	3	2	1	0
PAIN/SORENESS	4	3	2	1	0
BLURRED VISION	4	3	2	1	0
MUCUS/CRUSTY EYES	4	3	2	1	0

MEDICAL DRY EYE ACTIVITIES

WHAT ACTIVITIES ARE AFFECTED BY YOUR DRY EYES?

- ☐ CANNOT READ FOR LONG PERIODS OF TIME
- ☐ VISION FLUCTUATES WHILE READING/COMPUTER
- ☐ EYES ARE WATERY/ITCHY WHEN OUTSIDE
- ☐ EYES FEEL HEAVY ON THE COMPUTER
- ☐ CONSTANTLY RUBBING EYES
- ☐ EYES ARE RED AFTER COMPUTER USE
- ☐ EYES ARE HARD TO OPEN IN THE MORNING
- ☐ CONTACT LENSES ARE DRY OR CANNOT USE

CONTINUE →

PRIMARY CARE PHYSICIAN _____ PHARMACY NAME:_____
TELEPHONE #_____ TELEPHONE #_____
LAST PHYSICAL EXAM _____

DISEASE – CHECK ALL THAT APPLY	**MEDICATION(S)-PLEASE LIST OR CAN GREENLAKE EYE CARE ACCESS YOUR MEDICATIONS FROM AN ONLINE PHARMACY DATABASE → (CIRCLE ONE) YES NO**
☐ DIABETES (PRE--TYPE 1--TYPE 2)	
☐ HIGHT BLOOD PRESSURE	
☐ HIGH CHOLESTEROL	
☐ HEART DISEASE	
☐ STROKE	
☐ CANCER – (PLEASE SPECIFY)	
☐ THYROID DISEASE	
☐ ASTHMA	
☐ COPD/BREATHING DISORDERS	
☐ RHEUMATOID ARTHRITIS	
☐ DEPRESSION	
☐ ANXIETY	
☐ ATTENTION DEFICIT DISORDER(ADHD)	
☐ AUTISM	
☐ LUPUS	
☐ OTHER:	
☐ OTHER:	
☐ OTHER:	
☐ CURRENTLY PREGNANT: YES/NO	

☐ ***NO SIGNIFICANT 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				
MYOPIC DEGENERATION (HIGH NEARSIGHTED)				
CANCER				
DIABETES				
HIGH BLOOD PRESSURE				
HEART DISEASE				

☐ ***NO REMARKABLE FAMILY HISTORY***

EYE DROPS	***MEDICATION ALLERGIES***	***SOCIAL HISTORY***
1._____ 2._____ 3._____ 4._____ ☐ ***I DO NOT USE EYEDROPS***	1._____ 2._____ 3._____ 4._____ ☐ ***NO KNOWN DRUG ALLERGIES***	ALCOHOLIC BEVERAGES ☐ NONE ☐ RARELY ☐ SOCIALLY ☐ DAILY SMOKING ☐ NONE – NO PRIOR HISTORY ☐ NONE – PREVIOUS SMOKER ☐ 1 PACK/DAY ☐ 2+ PACKS/DAY

HIPAA Privacy Act

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your protected health information. 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. If 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 561.220.6272

I am aware of the privacy practices of Aronson Optometry, PA DBA GreenLake Eye Care.

_____
Initials

Insurance Assignment and Patient Responsibility

I certify that I (or my dependent) have insurance coverage with the above companies and assign directly to Aronson Optometry, PA DBA Greenlake Eye Care 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.

Vision Plans usually do not pay for any medical testing or treatments. Therefore, the patient will be responsible for any medical exam charges. All patient copays will be explained prior to testing and collected at the day of the exam. If your insurance does pay, we will refund that money to you.

Medicare/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, the refraction charge is $45.

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Initials

Consent to Dilation

A dilated eye exam is the portion of the eye exam that evaluates the structures and anatomy within the eye for conditions like *glaucoma, cataracts, macular degeneration, diabetic eye disease and retinal detachments*. This is accomplished using a series of eye drops. Common side effects include blurred vision, light sensitivity and redness and can last several hours.

- □ **YES**- I understand the purpose of Dilation and agree to have it performed when necessary.
- □ **NO**- I understand the purpose of Dilation but choose not to be dilated (You may return for another appointment) *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.* ***Please CHECK NO if you are currently (or might be) Pregnant***

Effective January 1st, 2022 **ALL** patients will be required to have a Retinal Photograph to assess and monitor the major structures of the eye. This test has a **$30 copay**. This test is not covered by insurance and is **mandatory** for all eye exams. Unfortunately, there will be no exceptions.

_____
Initials

Prescription Acknowledgements

I understand that my prescription for Glasses &/or Contact Lenses will always be available upon completion via the Patient Portal found on the company website. I understand that I can request a copy of my prescription be sent to me via email/fax however these methods are not 100% secure. We will attempt to restrict access to only the correct recipient but at times have encountered wrong recipients. A hard copy may be requested as well.

_____
Initials

I understand all the procedures and policies of GreenLake Eye Care.

_____
Signature

_____

_____

_____

Patient Name(s)