WELCOME TO THE OFFICE

PATIENT'S INFORMATION

NAME: _____
ADDRESS:_____
CITY: _____ State _____ Zip _____
DATE OF BIRTH: _____ / _____ / _____
SSN #: _____-_____-_____
OCCUPATION:_____
CELL PHONE #: _____-_____-_____
PHONE (OTHER):_____-_____-_____
EMAIL:_____

Reason for visit: (check all that apply)

- ☐ Glasses/General Health Exam
- ☐ Contact Lens Exam
- ☐ Lasik Consultation
- ☐ Emergency (specify) _____
- ☐ Other _____

How did you hear about us?..

- ☐ Insurance
- ☐ Mailer/Flyer
- ☐ Google/Yelp/Facebook
- ☐ Drive By Plaza
- ☐ Referral _____

INSURANCE INFORMATION

Vision Insurance _____
Subscriber Name _____
Subscriber ID#_____
Subscriber SSN# _____
Subscriber Birthdate _____/_____/_____

Many Medical Insurances will cover eye examinations as well! Please enter your information below so we can determine your coverage.

Medical Insurance _____
Subscribers Name _____
Subscriber ID#_____
Subscriber SSN# _____
Subscriber Birthdate _____/_____/_____

How will you settle your account today?
☐ Cash ☐Credit/Debit Card ☐CareCredit ☐HSA

(no personal checks)

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 for several hours, light sensitivity and redness.

☐ **YES**- I understand the purpose of Dilation and agree to have it performed.

☐ **CAMERA**- 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.

☐ **NO**- I understand the purpose of Dilation but choose neither to be dilated nor do I want a retinal photograph. (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.*

HIPAA PRIVACY ACKNOWLEDGEMENT

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. 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 561.220.6272

I am in receipt of notice of privacy practices of Aronson Optometry, PA DBA GreenLake Eyecare.

_____ _____/_____/_____
Signature Date

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

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/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:
  _____
  _____

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

Reset