

WELCOME TO THE OFFICE

PATIENT'S INFORMATION	INSURANCE INFORMATION
<p>NAME: _____</p> <p>ADDRESS: _____</p> <p>CITY: _____ State _____ Zip _____</p> <p>DATE OF BIRTH: ____ / ____ / ____</p> <p>SSN #: _____ - _____ - _____</p> <p>OCCUPATION: _____</p> <p>CELL PHONE #: _____ - _____ - _____</p> <p>PHONE (OTHER): _____ - _____ - _____</p> <p>EMAIL: _____</p> <p>Reason for visit: (check all that apply)</p> <p><input type="checkbox"/> Glasses/General Health Exam</p> <p><input type="checkbox"/> Contact Lens Exam</p> <p><input type="checkbox"/> Lasik Consultation</p> <p><input type="checkbox"/> Emergency (specify) _____</p> <p><input type="checkbox"/> Other _____</p> <p>How did you hear about us?..</p> <p><input type="checkbox"/> Insurance <input type="checkbox"/> Mailer/Flyer</p> <p><input type="checkbox"/> Google/Yelp/Facebook <input type="checkbox"/> Drive By Plaza</p> <p><input type="checkbox"/> Referral _____</p>	<p>Vision Insurance _____</p> <p>Subscriber Name _____</p> <p>Subscriber ID# _____</p> <p>Subscriber SSN# _____</p> <p>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 _____</p> <p>Subscribers Name _____</p> <p>Subscriber ID# _____</p> <p>Subscriber SSN# _____</p> <p>Subscriber Birthdate ____ / ____ / ____</p> <p><input type="checkbox"/> If you are interested in 0% financing for at least 6 Months, please check here.</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 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.</p> <p><input type="checkbox"/> YES- I understand the purpose of Dilation and agree to have it performed.</p> <p><input type="checkbox"/> NO- I understand the purpose of Dilation but choose <u>not</u> to be dilated (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>Effective January 1st, 2021 ALL patients will be required to have a Retinal Photograph to assess and monitor the major structures of the eye. This test has a \$10 copay. This test is not covered by insurance and is mandatory for all eye exams. Unfortunately, there will be no exceptions.</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 561.220.6272</p> <p>I am aware of the privacy practices of Aronson Optometry, PA DBA GreenLake Eyecare.</p> <p>_____/_____/_____ Signature Date</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

If you are interested in LASIK alternatives for all ages, please check here.

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)

MEDICATION ALLERGIES

SOCIAL HISTORY

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

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____

No Current Medications

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
 3+ packs/day

PLEASE RETURN TO FRONT DESK WHEN FINISHED-THANK YOU