Health History Form

Patient Name _____ **Birthdate**_____

Email Address:_____ **Cell Phone:** _____

Have you visited our office before? Yes____No___

Current Occupation_____

Family Doctor Name_____ **Phone:**_____

Date of last physical examination_____

Date of last eye exam and where_____ **Were you dilated? Yes_No___**

Height_____**Weight**_____ **Are you pregnant? Yes__No__**

Reason for visit:_____

_____

_____

Please check all the following conditions that you experience:

☐Headaches
☐Burning
☐Foreign Body Sensation
☐Mucous / Discharge
☐Sandy or Gritty Feeling
☐Blurred Vision Distance
☐Double Vision
☐Loss of Vision
☐Halos / Starbursts around lights
☐Glare/Light Sensitivity
☐Dryness
☐Infection of Eye or Lid
☐Drooping Eyelid
☐Lazy Eye
☐Blurred Vision Near
☐Floaters or Spots
☐Excessive Tearing
☐Flashes of Light
☐Tired Eyes
☐Eye Pain or Soreness
☐Itching
☐Redness
☐Crossed Eye
☐Distorted Vision
☐Fluctuating Vision
☐Loss of Side Vision
☐Excessive Eye Rubbing

Students:

☐Trouble following a line of print
☐Developmental issues
☐Trouble focusing on electronic device
☐Trouble focusing near to far

LASIK Surgery? Y N Date_____**Cataract Surgery? Y N Date**_____**Retinal Surgery? Y N Date**_____

Do you have or have a family history of any of the following:

	You	Family Member	Relation		You	Family Member	Relation
Amblyopia (Lazy Eye)				Glaucoma			
Blindness				Macular Degeneration			
Cataract				Retinal Detachment			
Color Blindness				Retinal Disease			
Corneal Disease				Strabismus (Eye Turn)			

If you marked any of the above or have a condition not listed, please explain below:

_____

_____

_____

Please list any eyedrops/eye ointments, dosages, frequency and why you take them:

_____

_____

Do you have any drug allergies? Yes____No___ If yes, please list:

_____

_____

Do you currently, or have you or any family member ever had any problems in the following Areas:

	You	Family Member	Relation		You	Family Member	Relation
Allergic/Immunologic				Dry Throat/Mouth			
Allergies/Hay Fever				Emphysema			
Anemia				Fever			
Asthma				Headaches			
Chronic Bronchitis				Heart Disease			
Chronic Cough				High Blood Pressure			
Constipation				Joint Pain			
Diabetes				Kidney/Bladder			
Diarrhea				Migraines			
Muscle Pain				Sinus Congestion			
Post-Nasal Drip				Skin Problems			
Psychiatric				Thyroid/Other Glands			
Rheumatoid Arthritis				Vascular Disease			
Runny Nose				Weight Loss/Gain			
Seizures							

If you marked any of the above or have a condition not listed, please explain below:

_____

_____

_____

List all major illnesses, injuries, or surgeries:

_____

_____

If diabetic, what was your last blood sugar and time_____ A1C(3 month average)_____

Please list any SYSTEMIC medications, dosages, frequency and why you take them

_____

_____

_____

_____

_____

Do you drink alcohol? Yes____No___ If so, how much?_____

Tobacco Use? Yes____No___ If so, how much?_____

Stopped Smoking? Yes____No___ When?_____

Do you use a computer? Yes____No__ If yes, how many hours/day?____

Do you drive? Yes____No___Do you have any problems driving? Yes____No___

If yes, please explain_____

Do you have any special hobbies?_____

Do you have problems with night vision? Yes____No___

Do you wear glasses? Yes____No___ If yes, how old are they?_____

Do you wear contact lenses? Yes____No___ If yes, what brand are they?_____

If you have your contact lenses inserted, how old are they?_____

Are you interested in trying contact lenses if you do not wear them? Yes____No___

Do you wear sunglasses? Yes____No___ If yes, how old are they?_____

Signature_____**Date**_____

Family Eye Care

Date_____

Patient Information

Name:_____Date of Birth: ____/____/____
What would you like to be called? _____
Gender: Male__ Female__ Language Preference: English__ Spanish__ Other__
Race: American Indian/Alaska Native__ Asian__ Black or African American__ Hispanic__
Native Hawaiian/Other Pacific Islander__ White__
Ethnicity: Hispanic/Latino__ Native Hawaiian/Other Pacific Islander__ Not Hispanic or Latino__
Marital Status: Married__ Divorced__ Widowed__ Single__
Mailing Address:_____
City: _____ State: _____ Zip Code: _____
Home Phone Number: (_____) _____ — _____ **Work / Day Phone Number:** (_____) _____ — _____
Cell Phone Number: (_____) _____ — _____ Is it okay to text you for appointment confirmations?_____
Preferred Way to Communicate: Home____ Cell____ Work____ Email____ Postal____
E-mail address:_____ @ _____
Employer:_____Occupation:_____

Northern Address (if applicable):_____
City: _____ State: _____ Zip Code: _____

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Emergency Contact Information

Name:_____Home Phone Number:_____
Address:_____Work Phone Number:_____
Relationship to patient:_____

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Responsible Party Information

Name of Responsible Person:_____Date of Birth:_____
Relationship to patient:_____
Mailing Address:_____Zip Code_____
Home Phone Number: (_____) _____ — _____ Work / Day Phone Number: (_____) _____ — _____
Cell Phone Number: (_____) _____ — _____
E-mail address:_____ @ _____
Employer:_____Occupation:_____

Health Insurance Information

Insured Subscriber Name:_____Relation: _____
Insured Subscriber ID Number: _____Date of Birth: _____
Insurance Carrier Name: _____
Employer: _____Work Phone: _____

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How did you hear about our office?

Doctor/Staff Member__Facebook__Family/Friends__Google__Mailer__Patient__FM105.1 Radio__Walk-In__Website__

Name of person who referred you to our office _____

Name and address of someone you would like us to send information about our office to:_____
_____

Guardian/Patient Signature:_____Date:_____

Family Eye Care
100 N Main Street
LaBelle FL 33935
(863) 675-0761

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Parrish and/or Dr. Youmans or their assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Lifetime Signature Date

_____ _____

Witness Date

FAMILY EYE CARE
LIFETIME CONSENT FOR RELEASE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS
AND FINANCIAL POLICY STATEMENT (Rev 09232013)

COMMERCIAL INSURANCE:
Family Eye Care will bill insurance provided we are a member of the network your company is involved with. We will verify the insurance coverage and let you know what, if any, percentage you will be responsible to pay. Payment is due on the date of service.

MEDICARE:
Family Eye Care will accept assignment from Medicare. You are responsible for the 20% co-payment on the date of service, any deductible that has not been met and any non-covered services and diagnoses, i.e. refraction, farsightedness, nearsightedness, etc.
If you have a Medicare supplement, we will file a claim with them provided they will make payment directly to our office.

Assurance of Medicare Compliance
Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare patients. It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

INSURANCE RELEASE:
I authorize Family Eye Care to release to my insurance company any required information regarding services provided for my care. I authorize any insurer or payor to make payment directly to Family Eye Care. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim.

FINANCIAL AGREEMENT:
I understand that my insurance contract is between my insurance company and me. If my insurance has not paid my claim within 30 days from the date insurance was billed, I will be responsible for payment. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance. I also understand that if I write a check and it is returned for any reason I will be charged a fee according to Florida Statute.

OUTSIDE LAB TESTING:
Occasionally, our doctors deem it necessary for lab work to be done. I understand this will be done by an outside agency and I will be responsible for payment to that agency for lab work done. _____Please initial that you have read and understand this.

RELEASE OF HEALTH INFORMATION:
In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, refer you to other health care providers, hospitals, or outpatient facilities that you have already or will identify to us. We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. The use and disclosure of your protected health information for treatment purposes not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional and/or pharmaceutical products. Similarly, the use and disclosure of your health information when using your insurance for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of your health information to auditors hired by third party payers and insurers such as the Social Security Administration or its intermediaries and carriers, Center for Medicare and Medicaid Services, Workers Compensation Carriers, Health Maintenance Organizations, Employers (when required), Welfare Funds, and Insurance Review Organizations among other aspects of payment described in our Notice of Privacy Practices. I authorize and consent to the release of any information, including, if applicable, any information about HIV infection or AIDS, information about substance abuse treatment and/or information about mental health services, as necessary. I also authorize Family Eye Care to email me at the email address I have provided to them regarding my care at Family Eye Care.

Lifetime Patient Signature_____ **/Date**_____

Do we have your permission to obtain medication history through the pharmacy/medical network? ___Yes ___No

Do we have your permission to talk to family members or other individuals about you? ___Yes ___No
If so, please list the name and relationship to you:
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

FAMILY EYE CARE
LIFETIME CONSENT FOR RELEASE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS
AND FINANCIAL POLICY STATEMENT (Rev 09232013)

MEDICARE PART B / COMMERCIAL INSURANCE SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits or any other insurance company be made either to me or on my behalf to Family Eye Care for any services furnished. I authorize and consent to any holder of medical or other information including the results of any HIV (human immunodeficiency virus) tests about me, to release to the health care financing administration, its agents, or other insurance company as noted any information needed to determine these benefits payable for related services.

Lifetime Patient Signature_____**/Date**_____

MEDIGAP SIGNATURE ON FILE:

I request that payment of authorized medigap benefits be made on my behalf to Family Eye Care for any services furnished. I authorize any holder of medical information about me to release to my medigap insurer any information needed to determine these benefits payable for related services.

Lifetime Signature of Beneficiary_____**/Date**_____

REFRACTION – NON COVERED SERVICES:

Medicare and most other insurance companies do not pay for the refractive part of any eye exam. If a refraction (part of exam that determines your need for glasses) is necessary during the exam, the insurance company will disallow it, stating it is not a covered benefit. Therefore, the patient will be responsible for the refraction charge.

Patient Signature_____**/Date**_____

WORKER'S COMPENSATION

I authorize and consent to treatment and release of any and all information, including the results of any HIV (Human Immunodefieiciency Virus) tests pertaining to my diagnosis and treatment to my employer, my employer's risk management department and/or my supervisor, as well as, the insurance carrier for my employer.

Patient Signature_____**/Date**_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge having received a copy of Family Eye Care's Notice of Privacy Practices. When you sign this document, you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. Furthermore, you certify that you have read and understand each of the above paragraphs and are the patient or the patient's legal representative/guardian with the power to execute this document and accept its terms.

A photostatic copy of this consent shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Guarantor/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

VERY IMPORTANT!!!!

We have started collecting email addresses and /or cell phone numbers to use for confirming appointments, appointment reminders and other electronic communication via a third party. Please sign below and enter your email address and cell phone number showing your authorization to be contacted by email and/or text.

Lifetime Patient Signature_____/Date_____
Email Address _____@_____._____
Cell Phone_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining acknowledgement

___ An emergency prevented us from obtaining acknowledgement

___ Other (please specify)