Patient Consultation Sheet

Contact Information (please print clearly): Date: _____

Name: _____
Last First M.I.

Address: _____
Street Address Apt/Unit

_____
City State Zip

Date of Birth: _____ Age:_____ Sex: _____ Marital Status: _____

Race (circle one): Asian (1) Caucasian (3) Hispanic (4) Black (6) Other (9)

Social Security Number: _____ Email: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Fax: _____

Employer: _____

Address: _____
Street Address City State Zip

Emergency Contact:_____
Name Phone Number

History and Questionnaire

1. Which is the best way to contact you? _____

2. What radio stations do you listen to? _____

3. Which newspapers do you read regularly? _____

4. How did you hear about us? _____

Radio -what station? _____ Newspaper - what paper? _____

Friend Newsletter Internet-what source? _____ TV -what station? _____
□ Billboard □ Health Fair/Trade show -please specify _____
□ Other _____ □ Corporate account -please specify _____

5. My main visual problem (check all that apply):
   - □ Fine Print
   - □ Near Vision
   - □ Intermediate/Computer
   - □ Distance Vision
   - □ Night Driving

6. My current prescription is for (check all that apply):
   - □ Myopia or nearsightedness
   - □ Hyperopia or farsightedness
   - □ Astigmatism
   - □ Presbyopia (bifocals or glasses for reading)
   - □ Unsure at this time

7. Do you currently wear: (check all that apply):

- ☐ Glasses for distance
- ☐ Progressive glasses
- ☐ Bifocal or reading glasses
- ☐ 1-2 week disposable contact lenses
- ☐ Monthly disposable contact lenses
- ☐ Vial contact lenses
- ☐ Extended wear contact lenses
- ☐ Toric contact lenses
- ☐ Trial contact lenses
- ☐ Monovision contact lenses
- ☐ RGP/Hard contacts
- ☐ Other _____

8. Do you have a history of any of the following (check all that apply):

- ☐ Keratoconus
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Thyroid Condition
- ☐ Glaucoma
- ☐ Keloid Former
- ☐ Past eye conditions _____
- ☐ Previous eye surgery _____

9. When was your last eye exam? _____

	Yes	No
10. Who is your present eye doctor? _____		
11. Did he/she refer you to us?	☐	☐
12. Has anyone ever told you that you would be a good candidate for the LASIK procedure?	☐	☐
13. Do you know any friends or family members who have had the LASIK procedure?	☐	☐
14. Is this your first vision correction consultation?	☐	☐
15. If you lost or misplaced your glasses or contacts, would you be .able to function throughout the day?	☐	☐
16. Do your glasses or contacts interfere with your recreational activities?	☐	☐
17. If you could function throughout the day without dependence on glasses or contacts, would you consider the procedure a success?	☐	☐
18. Did you know that LASIK is a two-step procedure?	☐	☐
19. Are you interested in learning about our financing program?	☐	☐

20. What is it about your glasses or contact lenses that currently prevent you from enjoying everyday activities?

_____

21. What do you-hope to achieve by having the LASIK procedure that glasses and contacts currently do not provide?

_____

22. How long have you been considering the LASIK procedure? _____

23. Do you have any fears regarding vision correction? _____

24. Is there anything preventing you from proceeding with the LASIK procedure prior to your visits other than financial arrangements? _____

25. When do you plan on having LASIK? _____

Name: _____ Date: _____

1. Place of employment: _____

2. Occupation or type of work: _____

3. Spouses name: _____

4. Spouses place of employment: _____

5. Spouses occupation or type of work: _____

6. Do you have any children?: _____

7. If yes, what are their ages? _____

8. What are your hobbies/interests? _____

9. How many hours a day are you on the computer? _____

TREATMENT AUTHORIZATION, ASSIGNMENT OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

1. **AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT** – I hereby consent to such diagnostic procedure and medical treatment which, in the judgment of my physician, may be considered necessary or advisable while a patient at the Jacksonville Eye Center.
2. **SOCIAL SECURITY MEDICARE** (if applicable) – I the undersigned, certify that the information given by me in applying for Medicare benefits is correct. I authorize Jacksonville Eye Center and my physicians to release to the Social Security Administration or its representatives any information needed to process this or any other related Medicare claims. I hereby assign payment on my behalf of all authorized benefits to Jacksonville Eye Center. I am personally responsible for any non-covered services, health insurance deductibles and co-insurance.
3. **MEDICAID** (if applicable) – I the undersigned, certify that I am a recipient of Medicaid benefits. I authorize Jacksonville Eye Center and my insurance carrier to make available to the Medicaid agency in my state any requested information concerning medical, insurance, and financial records relating to my care.
4. **COMMERCIAL INSURANCE AND ASSIGNMENT** – By signing in the space below as a patient and/or insured, I hereby assign patient from all insurance carriers with whom I have coverage or from whom benefits are, or may become payable to me, to be paid directly to Jacksonville Eye Center and to physicians who rendered services covering this period of treatment if related to the incident of condition giving rise to my treatment. This assignment shall include settlements or judgments flowing from the incident for which I was receiving treatment and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and any other period of treatment.
5. **RELEASE OF MEDICAL INFORMATION BY JACKSONVILLE EYE CENTER** – By signing in the space below as patient and/or guardian, I hereby authorize Jacksonville Eye Center and physicians providing service during my care to release information from and/or copies of my medical records, and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to Jacksonville Eye Center or my physician.
6. **GUARANTOR AGREEMENT** – By signing in the space below as patient and/or guardian, or guarantor or as a patients/guardians spouse, or guarantors spouse, I hereby agree that all charges connected with treatment, and past and future treatment if related to the incident or condition giving rise to the care not covered I may have are due and payable by me at the time of checking out. I hereby acknowledge that unless Jacksonville Eye Center and my insurance company or third party carrier have agreed that I will not be billed, Jacksonville Eye Center has the right to demand payment in full from me at the time prior to full payment from any insurance carrier. I hereby acknowledge having been told that I may be billed by my treating physician and/or Jacksonville Eye Center. If my account is referred to collections, I agree to pay attorney's fees, court costs and/or collection agency fees associated with the collection process. In addition, accounts older than 90 days referred to collections are subject to an 18% per annum interest charge. I specifically waive any exemption of wages from garnishment which might be available by law, and agree that my wages can be garnished in the event a judgment is entitled against me for the collection of services I have agreed to pay.

In addition to the above information, I also understand the following information:

1. **YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIANS AMEND YOUR PROTECTED HEALTH INFORMATION.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your record.
2. **YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE OF ANY OF YOUR PROTECTED HEALTH INFORMATION.** This right applies to other disclosures other than treatment, payment or healthcare operations as described in Notice of Privacy Practices, which, by signing below , you acknowledge receiving a copy of this document. It excludes disclosures we may have made to you, to family members, or to friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exception, restrictions, and limitations.
3. **YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US.**
4. **COMPLAINTS.** You may file a complaint to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact Linda Vencil at 904-355-5555 ext 139 for further information about the complaint procedure. .

Patient / Guardian _____

Insured (If different than above) _____

Witness _____

Date _____

JACKSONVILLE EYE CENTER

PLEASE DO NOT LEAVE ANYTHING BLANK – USE N/A (NOT APPLICABLE) IF IT DOESN'T APPLY

EYE HISTORY

Is this your annual eye exam? Yes / No Is this your first time here? Yes / No

What symptoms or problems are you having? (please circle all that apply – see below)

Blurred vision (near) / Blurred vision (distance) / Loss of vision / Double vision / Poor night vision

Distortion or halo's / Eye strain / Glare / Light sensitivity / Flashes of light / Floaters / Redness

Excessive tearing or watering / Foreign body sensation / Eye pain or soreness / Itching or burning

Mucous discharge / Eye infection / Stye / Twitching eyelid / Dry eyes / Headaches / Droopy eyelids

Other: _____

Do you have a known eye disease(s)? *(please circle all that apply)*

Cataracts / Glaucoma / Lazy eye / Macular degeneration / Retinal disease

Other: _____

Have you had previous eye surgery? *(please circle)*

Cataract R eye	Date:_____	Surgeon: _____
Cataract L eye	Date:_____	Surgeon: _____
LASIK or PRK R / L eye	Date:_____	Surgeon: _____
Glaucoma R / L eye	Date:_____	Surgeon: _____
Retina R / L eye	Date:_____	Surgeon: _____
Eye Muscle R / L eye	Date:_____	Surgeon: _____

Other: _____

Do you wear glasses? *(please circle)* Yes / No Do you wear contacts? *(please circle)* Yes / No

SOCIAL HISTORY

Do you drive? *(please circle)* Yes / No

Do you smoke? Yes - How many per day?_____ Quit- How long ago?_____ Never Smoked

Do you drink alcohol? Yes – How many per day/week?_____ Socially Do Not Drink

HEALTH HISTORY

Are you pregnant? _____ Nursing? _____ Height: _____ Weight: _____

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REVIEW OF SYSTEMS

Do you currently have or have had any of the following? Please circle all that apply.

Constitutional
Fever / Weight loss or gain

Neurological
Unusual headaches / Migraines
Dizzy spells / Vertigo
Fainting spells / Blackouts
Epilepsy / Seizures / Parkinson's
Depression / Anxiety / Mental disorders

Ears, nose & throat
Chronic allergies / Hay fever
Sinus congestion / Runny nose
Chronic cough / Dry throat / Dry mouth

Respiratory
Asthma / Chronic bronchitis
COPD / Emphysema / Shortness of breath

Other
Neuropathy

Cardiovascular
Heart condition / Chest pain
Pacemaker / Heart valve
Vascular disease / Heart murmur
Anemia / Bleeding problems
Congestive Heart failure

GI and GU
Diarrhea / Constipation / Crohn's
Kidney disease / Dialysis
UTI / STD / Ulcers / GERD
Hepatitis (which type) _____
Cirrhosis / Liver disease

Integumentary
Rheumatoid arthritis / Arthritis
Muscle pain / Fibromyalgia / Lupus
Skin disease / Skin cancer
Eczema / Rosacea
Rheumatoid arthritis / Arthritis

Please tell us about your health history, and that of your family:

	Self	**Family relationship** *(mother, father, brother, sister, aunt, uncle, grandmother, grandfather)*
Diabetes Yes / No		
High blood pressure Yes / No		
Thyroid disease Yes / No		
Cancer (list type) Yes / No _____		
Stroke / TIA (If yes, give date) Yes / No _____		
Heart attack (If yes, give date) Yes / No _____		
Shingles (If yes, give date) Yes / No Vaccinated? Yes / No _____		
Tuberculosis (If yes, give date) Yes / No _____		
HIV positive / AIDS Yes / No		

Previous surgeries (give dates if possible): _____

_____

_____

_____

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IT IS VERY IMPORTANT TO HAVE THIS INFORMATION!

IF YOU DON'T HAVE YOUR MEDICATION LIST, USE OUR COURTESY PHONE TO CALL YOUR PRIMARY DOCTOR TO FAX IT TO US! OUR FAX # (904) 355-9966

MEDICATION NAME	DOSAGE	HOW OFTEN IS IT TAKEN

Allergies and list reactions (ex: hives, vomitting, rash, etc): _____

_____

Drug sensitivities: _____

Have you ever taken a medication for your bladder or prostate? If so, give name _____

Pharmacy _____

Address _____

Phone # (_____) _____

PLEASE DO NOT LEAVE ANYTHING BLANK – USE N/A (NOT APPLICABLE) IF IT DOESN'T APPLY