JACKSONVILLE EYE CENTER

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

PATIENT INFORMATION *(please print clearly)* Date: _____

Patient's name: _____
Last First Middle Initial

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Date of Birth: _____ Age: _____ Sex: *(please circle)* Male / Female / Preference _____

Social Security Number: _____ Email Address: _____

Race: (please circle) White / Black / Hispanic / Asian / Other

Marital Status: (please circle) Married / Single / Separated / Divorced

Retired / Not working / Disabled / Student *(please circle all that apply)*

Employer: _____ Work Phone #: (_____) _____

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: (_____) _____

Referring Primary Care: Dr. _____ Phone #: (_____) _____

Referring Optometrist: Dr. _____ Phone #: (_____) _____

Endocrinologist (Diabetes): Dr. _____ Phone #: (_____) _____

Is patient a minor? / student? *(please circle all that apply)*

Parent/Guardian Name: _____ Phone #: (_____) _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Patient's Insurance: *(please circle)* Self / Spouse / Parent

If Spouse or Parent, Name: _____

Social Security #: _____ Date of Birth: _____

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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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REFRACTION POLICY

A refraction is an essential part of an eye examination and is necessary to write a prescription for glasses, contact lenses or to detect vision loss. A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider refraction "vision" services, not a "medical" service. Medicare's benefit policy (100.02, Section 90) states: "Routine physical checkups; eyeglasses, contact lenses and eye examinations for the prescribing, fitting, or changing eye glasses; eye refractions by whatever practitioner and whatever purpose performed; hearing aids; and immunizations are not covered." We will NOT file the charge for a refraction with a health insurance plan unless we know that your plan covers the refraction charge. ***Our office fee for a refraction is $60.00 and this fee is collected at the time of service in addition to any co-payment your plan may require.*** Should your plan pay us for the refraction, we will reimburse you accordingly.

DILATION POLICY

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable dark sunglass inserts or wrap-arounds. Patients should wear sunglasses, even if you're not driving; be cautious walking and going up or down stairs.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Jacksonville Eye Center's privacy notice. I understand that I am responsible to read this notice and notify the Jacksonville Eye Center, in writing, of any request for restrictions in the use or discloser of my individually identifiable health information. Jacksonville Eye Center has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. Jacksonville Eye Center will provide me with a copy of its most recent notice upon my request.

Patient Signature: _____ Date _____

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 _____

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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): _____

_____

_____

_____

JACKSONVILLE EYE CENTER

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 # (_____) _____

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