Jacksonville Eye Center

Patient Name _____ Date: _____

Age: _____ Height: _____ Weight:_____

Family Doctor: _____ Doctor's Phone # _____

Allergies and Reactions:	Drug Sensitivities

Please list all medications including prescriptions and over the counter or provide an attached list.

Have you ever taken FIomax? □ Yes □ No

Medication Name	Dosage	Medication Name	Dosage	Medication Name	Dosage

Yes	No	HAVE YOU EVER HAD OR STILL HAVE?
□	□	High Blood Pressure
□	□	Heart Murmur
□	□	Palpitations/Irregular Heart Beat
□	□	Chest Pain/Angina
□	□	Heart Attack Dates: _____
□	□	Angioplasty/Coronary Stents Dates_____
□	□	Heart Surgery Dates: _____
□	□	Congestive Heart Failure
□	□	Shortness of Breath Climbing Stairs
□	□	Shortness of Breath Walking
□	□	Shortness of Breath at Rest
□	□	Pacemaker/Defibrillator Last checked? _____
□	□	Cold in Past 2 Weeks
□	□	Fever in Past 48 Hours
□	□	Smoked Tobacco in the Past Year? Packs Per Day _____
□	□	Asthma/Bronchitis/Chronic Cough
□	□	Emphysema/COPD
□	□	Pneumonia in past 6 months?
□	□	Tuberculosis/Asbestosis
□	□	Sleep Apnea
□	□	CPAP Use regularly? _____
□	□	Kidney Problems
□	□	Dialysis

Yes	No	HAVE YOU EVER HAD OR STILL HAVE?
□	□	Stroke/TIA
□	□	Convulsion/Epilepsy
□	□	Blackouts
□	□	Back Pain/Disc Disease
□	□	Back Injury/Paralysis
□	□	Arm or Leg Numbness/Muscle Weakness
□	□	Frequent or Severe Headache Type _____
□	□	Hepatitis/Jaundice
□	□	Cirrhosis/Liver Disease
□	□	Stomach or Intestinal Ulcers
□	□	Reflux Esophagitis/GERD
□	□	Diabetes
□	□	Thyroid Disease
□	□	Anemia
□	□	Blood Transfusion
□	□	Sickle Cell Disease/Porphyria
□	□	Rheumatoid Arthritis
□	□	Recent Abnormal Weight Loss
□	□	Weight Reduction Meds
□	□	Alcohol Consumption? Drinks per day____
□	□	Is there any chance you could be pregnant?

Previous Surgeries Requiring Hospitalization: _____

_____

Patient Information

Contact Information (please print clearly): Date: _____

Name: _____
Last First M.I.

Social Security Number: _____ Email: _____

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)

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Fax: _____

Employer: _____

Address: _____
Street Address City State Zip

Emergency Contact: _____
Name Phone Number

Were you referred to us by another physician? If so, who? _____

If patient is a minor or full time student under parent/guardian's insurance: Full time student: _____ Part time: _____

Parent/Guardian Name: _____ Phone number: _____

Parent/Guardian Employer: _____

Insurance Information (please print clearly):

(If Applicable) Medicare Number: _____ Medicaid Number: _____

My insurance is in: (check one) My name: _____Spouse's name: _____ Parent/Guardian: _____

Subscriber's Name: _____

Subscriber's Social Security Number: _____ Date of Birth: _____

Primary Insurance Company: _____

Group Number: _____ Policy Number: _____

Secondary Insurance Company: _____

Group Number: _____ Policy Number: _____

Eye History

Name: _____ Date: _____

Thank you for choosing our office for your eye care needs. To better serve you, please answer the following questions:

1. What is the reason for your visit today? _____

2. Do you wear glasses? □Yes □No Do you wear contacts? □Yes □No

3. Do you have problems reading?

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of light	Halos
Discharge	Light Sensitivity	Double Vision	Decreased Vision	Floaters

5. Have you ever had an eye injury? Please describe: _____

_____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____R/L_____

_____R/L_____

7. Are you currently using and eye medications? Please list name and how often used _____

_____

8. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes	Heart Disease	High Blood Pressure	High Cholesterol
Stroke	Arthritis	Other: _____	

9. **Please list ALL medications you take**: _____

_____

10. Are you allergic to any medications? Please list: _____

_____

11. Do you have a family history of eye problems? Please circle and list family relationship

Glaucoma	Cataract	Retinal Disease	Macular Degeneration

12. Please circle any of the following that you would like more information about:

LASIK or PRK	Contac\ Lenses	Multifocal Lens Implants	
Diabetic Eye Disease	Glaucoma	Cataract Surgery	Other _____

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 serviced 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 patient's/guardian's spouse, or guarantor’s 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 PHYSICIAN 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 Pl'9v1de 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 disclosures other than treatment, payment or healthcare operations as described In -Notices 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: _____