Welcome to Alafaya Vision Center **PLEASE PRINT CLEARLY**

Mr. / Ms. / Mrs. / Dr. First name_____Last Name: _____
Sex: ☐F☐M Birthdate:_____ Age: _____SSN:_____(We need this to look up insurance) Address: _____
City _____State:_____Zip:_____
Email address:_____

Cell phone number: (_____) _____Emergency number: (_____) _____
Emergency contact: _____Relationship:_____
Marital Status: ☐Single☐Married☐OtherEmployment:☐Retired☐Unemployed☐Employed☐Student
Employer: _____Work Phone :(_____) _____**Your Occupation:_____
Primary Care Physician: _____Physician Phone Number :(_____) _____
Last Eye Doctor: _____
How did you hear about our practice:☐Walk-In☐Insurance☐LensCrafters Website ☐Alafaya Vision Center Website☐Google☐Yelp☐Previous Patient Full Name: _____

INSURANCE INFORMATION ☐NONE/SELF PAY

Vision Insurance: _____MedicalInsurance_____
Vision Insurance ID#_____ Group#_____
Medical Insurance ID#_____ Group#_____
Person responsible for bill (if different from patient) Guarantor Name: _____

SSN: _____ Birthdate_____Relationship to patient: Spouse Child Domestic partner
Phone #_____Employer:_____
Address:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed and accept the terms of the Alafaya Vision Center Notice of Privacy Practices. *Signature:_____Date:_____*

CONTACT LENSES (Please circle)

Have you ever worn contact lenses: **YES NO**
When was the last time you used contact lenses:_____
What type of Contacts do you wear? (Please check ALL responses that apply)

☐HARD lenses w/ ☐ASTIGMATISM☐REGULAR ☐MULTIFOCAL/BIFOCAL ☐MONOVISION(one for near one for far)

OR

☐SOFT lenses w/ ☐ASTIGMATISM☐REGULAR ☐MULTIFOCAL/BIFOCAL ☐MONOVISION(one for near one for far)

CONTACT LENS CARE AND INSTRUCTIONS- Please review and follow:

First Name_____Last Name_____Birthdate_____

Cell phone number:_____

YOUR DOCTOR WILL DISCUSS WITH YOU WEARING & REPLACEMENT SECHDULE FOR YOUR CONTACTS. REMOVE LENSES PROMPTLY AND DISCONTINUE WEAR IF YOU ARE EXPERIENCING ANY OF THE OCULAR SYMPTOMS BELOW:

Discomfort or pain
Blurred, cloudy or foggy vision
Redness of the eye
You suspect something is wrong
Eyes feel irritated
Foreign body sensation

Call the prescribing doctor for a consult if any of the above signs and/or symptoms are noted. If you believe you are having a true ocular emergency after hours please visit your local ER.

Important points about contact lenses:

Absolutely NO sleeping in contact lenses unless indicated
Wash hands thoroughly before handling contact lenses
Insert contacts prior to application of makeup, lotions, creams etc…

NOT FOLLOWING PROPER CONTACT LENSES CARE, REPLACEMENT, USE AND HYGIENE PROTCOLS CAN RESULT IN POTENTIALLY BLINDING MICROBIAL INFECTIONS OF THE EYE

PRESCRIPTION EYEGLASSES: As a contact lens wearer you should maintain a pair of prescription glasses. Contact lenses are not to be your only means of vision correction. NON-PRESCRIPTION SUNGLASSES: Quality sunglasses with adequate UV protection are essential for all patients in order to protect your eyes from the sun.

PATIENT STATEMENT: *I have read the information provided above. I understand that compliance and follow-up care is extremely important with contact lens use and that it is my responsibility to schedule and keep my follow-up appointments. If I fail to do so, I will not hold this office responsible for any eye health related problems.*

Signature: _____Date:_____

OFFICE FINANICAL POLICY: We are pleased you have selected us as your eye care provider. For your knowledge, our financial policy is outlined below. Promise to pay: Amounts for services provided to you or your family members that are minors may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for the services may be estimated based on the amount anticipated to be paid by your insurance company. Insurance claims, benefit, and coverage information are agreed upon between the patient and insurance company and are ultimately the patient's responsibility. In the event that you insurance company is slow to pay or disallows a claim payment, the account balance is your full responsibility. REFUND POLICY: Services: Our staff and our doctors take the upmost care with each patient to provide the best possible services. **Eye exam and professional fees are not refundable**. Contact lenses: **There are no refunds on contact lens purchases. Unopened, unmarked boxes of contacts may be exchanged within 30 days of purchase**. Additional charges may be applied to your account for the below reasons: Late payment fee: If we do not receive payment in full of your balance within 30 days of the statement date shown on your statement, you will be a assessed a late payment fee of $25.00 and then 2% of your unpaid balance each month that the balance is not paid in full. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your balance. Returned payment fee: If any check or other payment that you have made on your Account is returned unpaid, you will be charged a return payment fee, which is $25.00. **Contact lens wearers**: **You have 30 days from the initial fit of your contacts lenses** to have (3) progressive follow up visits at no charge; certain restrictions may apply especially with rigid gas permeable lenses and if during the contact lens fitting period you develop any corneal/contact lens complications, infection of the eye, or any other ocular condition**. I understand that I will be charged for any adjustments after the free follow-up period and the replacement of any lost or damaged lenses**. NO EXCEPTIONS ARE MADE TO THE REFUND/FINANCIAL POLICY ABOVE.

Communications. By signing this policy you are consenting to allowing our office to communicate with you via phone, text, email, & mail. This communication can include but is not limited to your patient records, receipts and promotional matters.

Signature:_____Date:_____

INFORMED CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

A dilated exam is a complete exam that helps the doctor detect cataracts, glaucoma, retinal disease, detachments, malignancies and much more, all of which can lead to permanent vision loss**. Side effects of dilation typical lasts 4-6 hours, including blurry vision close up and distance. Other side effects include light sensitivity and mild burning upon instillation of drops. In RARE cases induced ocular hypertension with redness, sharp pain, blurry vision and nausea can occur. If this happens seek immediate medical attention.PLEASE SELECT AN OPTION AND SIGN BELOW**

☐ **Yes, I have read the above and consent to the dilation procedure.**

☐ **I refuse the dilation procedure and understand the risks associated with not dilating my eyes today.**

Sign_____Date_____

Medical History

Are you Pregnant or Nursing?☐Yes☐NoLast eye exam:_____ Are you Diabetic?☐Yes☐No
Last fasting blood sugar_____Date_____HbA1c_____Date_____Last visit w/PCP/MD_____
Average fasting blood sugar_____List ANY medication allerigies_____
List Current Medications:_____

_____

List major injuries/surgeries/hospitalzations:_____
Any eye surgeries?☐Yes☐No: List here:_____
Do you wear glasses ☐Yes ☐No, Contacts ☐Yes ☐No, Contacts lens brand:_____
Do you use tobacco products?☐Yes☐No **If yes, type/amount/how long**_____**Have you been exposed or infected with:**
Do you drink alcohol?☐Yes☐No **If yes, type/amount/how long**_____ ☐*Gonorrhea* ☐*Hepatitis* ☐*HIV* ☐*Syphilis*

Family History

Ocular/Systemic Conditions	Family Member Affected (Maternal/Paternal)
☐Blindness due to Disease	
☐Blindness due to Injury	
☐Glaucoma	
☐Macular Degeneration	
☐Retinal Detachment	
☐Retinal Degeneration	
☐Arthritis	
☐Cancer ☐Type:	
☐Diabetes	
☐Heart Disease	
☐Hypertension	
☐Kidney Disorder	
☐Thyroid Disease	
OTHER	

IF NONE OF THE ABOVE, INITIAL HERE ___

Patient History/Review of Systems

Cardiovascular ☐Heart Disease ☐Elevated Cholesterol ☐High Blood Pressure	**Hematologic** ☐Anemia ☐Coagulation Disorder ☐Leukemia	**Musculoskeletal** ☐Arthritis ☐Muscle Pain ☐Joint Pain ☐Rheumatoid arthritis	**Integumentary (Skin)** ☐Lupus ☐Psoriasis ☐Eczema
Gastrointestinal ☐Diarrhea ☐Constipation	**Respiratory** ☐Asthma ☐Bronchitis ☐Emphysema	**Endocrine** ☐Diabetes ☐Thyroid Dysfunction	**Psychiatric** ☐ADD/ADHD ☐Anxiety ☐Depression
Constitutional ☐Fever ☐Weight Gain ☐Weight Loss	**Genitourinary** ☐Kidney Problems ☐Bladder Problems	**Ears/Nose/ Throat** ☐Chronic Cough ☐Dry Mouth ☐General Allergies ☐Head Colds	**Eyes** ☐**Crossed Eyes** ☐**Lazy Eye** ☐**Glaucoma** ☐**Retinal Disease** ☐**Retinal Detachment** ☐**Cataract** ☐**Other**
Neurologic ☐Headaches ☐Migraines ☐Seizures ☐Multiple Sclerosis			

IF NONE, INITIAL HERE_____

OCULAR HISTORY-CIRCLE YES OR NO

Please note any other medical or ocular conditions not listed:

Blurry Vision	**Y N**	**Dryness**	**Y N**	**MucousDischarge**	**Y N**	**Floaters**	**Y N**
Double Vision	**Y N**	**Redness**	**Y N**	**Eye Pain**	**Y N**	**Flashes**	**Y N**
Eye Fatigue	**Y N**	**Itching**	**Y N**	**Light Sensitivity**	**Y N**	**Distorted Vision/Halos**	**Y N**
Loss of side vision	**Y N**	**Burning**	**Y N**	**Watery Eyes**	**Y N**	**Other**	

Name:_____Birthdate:_____Date:_____

Signnature: _____Cell phone number:_____