Family Eye Care & Vision Therapy

Basic Information

Salutation ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof **Suffix** _____ (eg. Jr, Sr)

First name _____ **Cred.** _____(eg. OD MD)

Last name _____**Nickname** _____

Middle name _____ **Pronunciation** _____

Home Address

Address _____

_____

City _____

State/Prov _____

Zip code _____

Other Information

Date of Birth ____/____/_____

SSN _____

Guarantor ☐ Self ☐ other_____

Sex ☐Male ☐ Female

Language _____

☐ decline

Phone/Email

Prefer ☐ Home ☐ Work ☐ Cell

Home _(____)_____ x _____

Work _(____)_____ x _____

Cell _(____)_____ x _____

Email _____

☐ decline to supply email

Races ☐ All other races

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ decline

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ decline

Referred by

☐ Patient _____

☐ Doctor _____

☐ Other _____

☐ advertisement ☐ physical therapist

☐ family, friend, co-worker ☐ professional referral

☐ insurance ☐ occupational therapist

☐ internet - website ☐ school/ study center

☐ internet - reviews, media ☐ sign/ drive by

☐ None ☐ other _____

Employment/School status

☐ Employed Full Time ☐ Not Employed ☐ Active Military

☐ Employed Part Time ☐ Retired ☐ Disabled

☐ Student Full Time ☐ Homemaker

☐ Student Part Time

Employer _____ **Position** _____

Please select and fill in all that apply including None:

Current Medication List

Please **Provide a list** of ***all*** your medications with dosages - ***include***: prescription, over-the-counter and vitamins

☐ ***None***

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems

Constitutional (affecting whole body)
- ☐ ***None***
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other _____

ENT
- ☐ ***None***
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other _____

Neurological
- ☐ ***None***
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder
- ☐ Other _____

Psychiatric
- ☐ ***None***
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other _____

Cardiovascular
- ☐ ***None***
- ☐ Hypertension/ High Blood Pressure
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other _____

Respiratory
- ☐ ***None***
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other _____

Gastrointestinal
- ☐ ***None***
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other _____

Genitourinary
- ☐ ***None***
- ☐ Kidney disease
- ☐ Prostate disease/cancer
- ☐ STD - herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other _____

Musculoskeletal
- ☐ ***None***
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other _____

Integumentary
- ☐ ***None***
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ Other _____

Endocrine
- ☐ ***None***
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other _____

Hematologic/ Lymphatic
- ☐ ***None***
- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Ulcer
- ☐ Hypercholesteremia/ High Cholesterol
- ☐ Other _____

Allergic/Immune
- ☐ ***None***
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other _____

Please select and fill in all that apply including None:

Allergies

Medication Allergies

☐ ***No known medication allergies***

☐ Medication name(s)

_____ _____ _____

_____ _____ _____

Other Allergies

☐ ***No known allergies***

☐ Environmental - airborne

☐ Environmental - seasonal

☐ Environmental - animal dander

☐ Environmental - latex

☐ Food - dairy

☐ Food - nuts

☐ Food - shellfish

☐ Bee stings

☐ Other _____

Severity: ☐ mild ☐ moderate ☐ severe

Past Ocular History

Eyes

☐ ***None***

☐ Glaucoma Suspect

☐ Glaucoma

☐ Cataract

☐ Age-related Macular Degeneration

☐ Surgery

☐ Patching

☐ Inflammatory Disorder

☐ Strabismus/ Crossed Eye(s)

☐ Amblyopia

☐ Retinal Degeneration/Hole/Detachment

☐ Retinal Degeneration

☐ Retinal Hole

☐ Retinal Detachment

☐ Keratoconus

☐ Injury

☐ Dry Eye

☐ Nystagmus

☐ Other _____

Social History

Drinking

☐ Yes Amount _____

☐ No

Tobacco Use

☐ Yes

☐ No

Smoking Status

☐ Never smoker

☐ Former smoker

☐ Current some day smoker

☐ Current every day smoker

☐ Unknown

Hobbies _____

Family Medical History

Family Medical Conditions

☐ **None**

☐ Hypertension

☐ Diabetes

☐ Cancer

☐ Thyroid

☐ Other _____

Family Eye Conditions

☐ **None**

☐ Cataract

☐ Glaucoma

☐ Glaucoma Suspect

☐ Macular Degeneration

☐ Amblyopia (Lazy Eye)

☐ Severe Myopia (Nearsighted)

☐ Severe Hyperopia (Farsighted)

☐ Strabismus (Crossed Eyes)

☐ Retinal Detachment

☐ Dry Eye

☐ Nystagmus

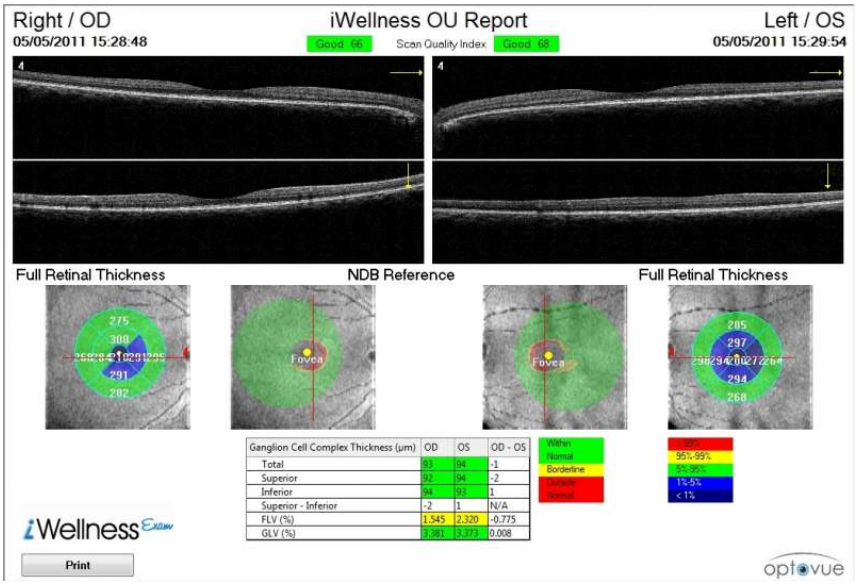
☐ Other _____

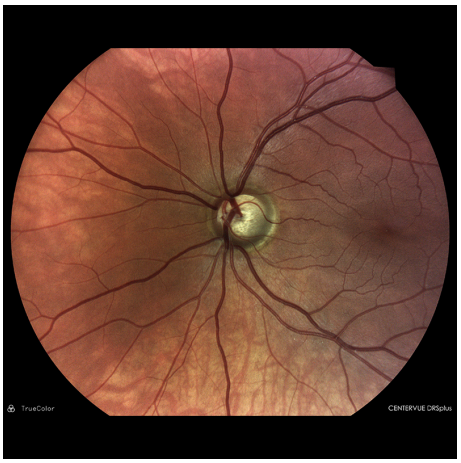
Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy generally have no outward signs or symptoms in the early stages.

The *iWellness Exam* is a quick, non-invasive scan which reveals ocular anatomy and signs of disease in fine detail that are invisible using traditional methods. This advanced technology can help detect potential vision threatening diseases early on when they are most treatable.

Your visit will include a *retinal imaging* of the inside of your eyes. This gives a detailed view of the health and appearance of your eyes and provides a record that we can use to help identify any changes in the future.

The fee for this is $39 and is not covered by your vision or medical insurance. May we include these valuable state-of- the art tests with your exam today? ☐ YES ☐ NO





Dilation of the Pupil

Dilation of the pupil is the standard level of care required in the State of Florida for all new patient comprehensive exams. It allows for a more complete evaluation of the health inside of the eyes. The most common side effects are sensitivity to light and blur mostly with near vision. Sunglasses will provide relief from the light sensitivity. Sun protection will be provided if needed. The average length of time for the eyes to return to normal is 3-5 hours.

Be prepared to have your eyes dilated during the visit unless you notify the staff and Doctor that it cannot be done on that day.

Family Eye Care & Vision Therapy

Patient consent to use and disclosure of Health Care Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand as part of treatment, payment or healthcare operations it may become necessary to disclose health information to another entity (i.e. referrals to other healthcare providers and insurance companies for payment). I understand this information serves as:

- A basis for planning my care and future treatment
- A means of communication among healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third party can verify that services billed were provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

A copy of "Notice of Patient Privacy Practices" which provides a more complete description of information uses and disclosures of your health information is available to you, at your request.

I give permission to share appointment, treatment, and payment information with the persons named below*:*
Example: Immediate family members (parents, spouse, and children).

Name(s):_____

Office/Patient Communication

It is very important for our office to communicate with our patients. Family Eye Care & Vision Therapy uses various methods that may include phone, text messaging and email, for appointment reminders, recall reminders, order information and other business-related activities as needed.
You may opt out of a particular form of communication upon request.

I give permission for Family Eye Care & Vision Therapy (the provider, its employees, agents, and assignees) to use the methods of communication indicated and I have been provided the opportunity to read and retain a copy of "Notice of Patient Privacy Practices".

Print name_____ Date____/____/_____

Signature_____
(parent/ guardian of minor)

Consent to file all Medical and Vision Insurance and Private Pay responsibility

Vision insurance covers routine eye exams, glasses or contact lenses. Medical insurance covers disease, problems or injury to the eye. Our office must adhere to the guidelines set forth by your insurance companies. Those guidelines determine which plan our office must bill for today's visit. The patient is responsible for all copays and deductibles required by each insurance plan.

Medicare and most medical plans do not pay for the refractive part of an eye exam. The refraction is what determines your need for glasses. The patient is responsible for this charge.

I request that payment of authorized Medicare benefits, or other insurance be made either to me, or on my behalf to Family Eye Care & Vision Therapy, Inc. for any services provided. I authorize any holder of medical information about me to release to the health care financing administration and its agents that information needed to determine the benefits payable for related services.

Private pay patients are responsible for payment at time of services for exam and material related charges.

Print name_____ Date____/____/_____

Signature (responsible party) _____

Family Eye Care & Vision Therapy

Authorization for Disclosure of Protected Health Information to Patient Portal

I hereby authorize Family Eye Care & Vision Therapy to use/disclose my individually identifiable health information to the Patient Portal at www.familyeyecarevt.com.

Patient Name: _____ Date of Birth:____/____/_____
(please print) First Middle Last

Mailing Address:

_____
Street City State Zip

Email address where patient portal messages will be sent: _____

- I understand that I MAY REFUSE TO SIGN this authorization and that my health care and treatment will not be affected if I do not sign this form.
- The purpose of the Patient Portal is to make routine, non-emergency communication more convenient and to provide you with better access to your health information. Family Eye Care is not responsible for a breach of this information if the patient using the portal is using a computer workstation or device that could be compromised.
- We will normally respond to messages within 24 business hours Monday – Thursday. We do not respond to messages on the weekend. If you need more immediate assistance, please call 941-966-6700. DO NOT use the Patient Portal to communicate if there is a medical emergency.
- All electronic communication from you to the practice should be through the Patient Portal. Do not use your regular e-mail account to send us confidential information since regular email is not secure and information you send via email can be viewed by third parties.
- These policies and procedures are subject to change without prior notice. We retain the right to modify, discontinue or suspend the portal service for any reason at any time.

____/____/_____ _____ _____
Date Signature of individual or representative relationship *(if representative)*

Please do not write below this line

Patient Portal at www.familyeyecarevt.com

Your user name is :_____

Your temporary password is :_____

- Email address entered into EHR
- Patient temporary password assigned
- Copy of form given to patient

- Form scanned into patient's EHR.

Employee initials _____ Date ____/____/_____