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

Status ☐ New patient ☐ Established patient

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 ☐ sign/ drive by

☐ internet ☐ school/ study center

☐ occupational therapist ☐ yellow pages

☐ None

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:

Current Medication List

Please list ***all*** your medications - ***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 ______________________________

Hemotologic/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:

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 ____________________________

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

☐ Current every day smoker
☐ Current some days smoker
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Never smoker

Family Medical History

Relationship: (F) Father, (M) Mother, (Bro) Brother,
(Sis) Sister, (S) Son, (D) Daughter

Family History

☐ Unknown For All Immediate Family Members

Cancer

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Diabetes Mellitus in first degree relative

☐ No
☐ Yes

☐ Unknown Type; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

☐ Diabetes Mellitus Type 1; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

☐ Diabetes Mellitus Type 2; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Hypertension

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Hyperthyroidism

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Hypothyroidism

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Cataract

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Macular Degeneration

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐ D

Glaucoma

☐ No
☐ Yes; Relationship:

☐ F ☐ M ☐ Bro ☐ Sis ☐ S ☐

iWellness Exam

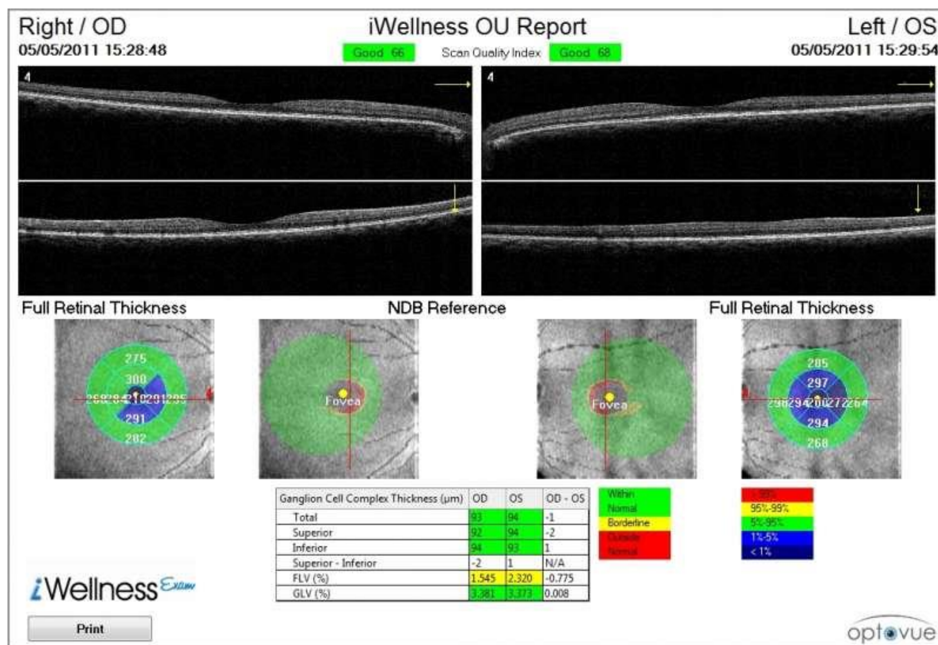
Powered by optovue

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 initial visit will include a digital photograph of the inside of your eyes. This gives us a record of the health and appearance of your eyes 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 actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

Indicate what we may contact you about and ALL accepted methods of contact:

	yes	no	Home#	Work#	Cell#	Email	Mail
Appointment confirmation	☐	☐	☐	☐	☐	☐	-
Recall reminder	☐	☐	-	-	-	☐	☐
Order information	☐	☐	☐	☐	☐	☐	-

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):____

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 for Family Eye Care & Vision Therapy 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)

Patient/Guardian consent for filing Medical/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. I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay and fails to do so.

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 on my behalf to Family Eye Care & Vision Therapy, Inc. for any services provided and that I will turn over to Family Eye Care & Vision Therapy any insurance payment made directly to me. 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
694 S. Tamiami Trail
Osprey, FL 34229
941-966-6700

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 __________