

Patient name: _____ Date of Birth _____ Sex: Male / Female

1. Primary Care Doctor / Pediatrician's Name: _____
2. When was your last eye exam? _____ By which eye doctor? _____
3. What pharmacy do you prefer? _____ What city is the pharmacy in? _____

MEDICAL HISTORY: List any medical conditions you have ever been diagnosed with by a doctor:

Check if applies	Conditions	Check if applies	Conditions
	ADHD		Kidney disease
	Anxiety		Liver disease
	Asthma		Lung disease
	Autism		Lupus
	Bleeding disorder		Macular degeneration
	Cancer		Migraines
	Cerebral Palsy		Nerve/brain disorder
	Depression		Pacemaker
	Developmental Delay		Paralysis
	Diabetes		Rheum. arthritis
	Down's syndrome		Sickle Cell Disease
	Glaucoma		Sjogren's syndrome
	Heart disease		Stroke / TIA
	High blood pressure		Thyroid disease
	High cholesterol		Other:

SURGICAL HISTORY INCLUDING EYE SURGERIES: List all surgeries you have had:

Date /	Procedure	4. /
1. /		5. /
2. /		6. /
3. /		7. /

FAMILY HISTORY: List medical conditions your relatives have had (not the patient):

Check if applies:	Condition	Check if applies:	Condition
	Eye misalignment		Cancer
	Droopy eye lid		Diabetes
	Poor vision in one eye		Thyroid disease
	Blindness		Heart disease
	Juvenile cataract		High blood pressure
	Macular degeneration		High cholesterol
	Glaucoma		Stroke
	Retinal problem		Other condition:
	Rheumatoid arthritis		Other condition:

SOCIAL HISTORY: Please answer the following questions.

Do you drink alcohol? () Never () Social/Occasionally () Moderately () Heavily
Smoke tobacco? () Never () Former Smoker () Current Some Day Smoker () Current Every Day Smoker
Do you do any illicit drugs? () Yes () No If so, what drug? _____

BIRTH / PRENATAL HISTORY: For children 17 and under only:

Check one: The patient is ____ my biological child, ____ adopted, ____ a foster child, ____ other:
Patient was born at ____ weeks gestation
List complications during pregnancy or birth:
Check one: Born by ____ vaginal ____ c-section
Patient's birth weight was ____ Lbs ____ Oz
How long was patient in NICU after birth? ____ Never; For ____ days, weeks, months
Was the patient on oxygen while at the hospital? ____ yes ____ no
Patient lives with: () biological mom () biological dad () step-parent () legal guardian () foster-parent () other:

ALLERGIES TO MEDICATIONS: List all your allergies to medications:

Medication / Reaction	4. /
1. /	5. /
2. /	6. /
3. /	7. /

CURRENT MEDICATIONS: List all your current medications:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

FOR DIABETIC PATIENTS ONLY:

What was your blood sugar today?
What range is average for your blood sugar, high and low?
What was your last A1c lab score? ____ % When was this performed? _____

REVIEW OF SYSTEMS: Please check any problems that you feel currently applies to you:

Check if applies:		Check if applies:		Check if applies:		Check if applies:	
	Balance problems		Chest pain		Cough		Shortness of breath
	Congestion		Cramps		Difficulty Swallowing		Weight loss
	Dry mouth		Easy bleeding		Fatigue		Weight gain
	Fever		Hard of hearing		Heart Murmur		Skin lesion
	Heat Intolerance		Cold Intolerance		Impotence		Swelling
	Increased thirst		Painful urination		Rash		Headaches

PNEUMONIA VACCINE: For people 65 or over only:

Have you ever had a pneumonia vaccine? () Yes () No

Please Print Clearly

Name: _____ Referred By: _____
 Date of Birth: _____ PCP (Full Name): _____
 Address: _____ PCP Phone Number: _____
 City: _____ State: _____ Zip: _____ Email Address: _____
 Cell Phone: _____ Male: _____ Female: _____
 Home Phone: _____ Social Security Number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____
 Name on Insurance Card: _____ Name on Insurance Card: _____
 Insured's Date of Birth: _____ Insured's Date of Birth: _____
 Relationship to Patient: _____ Relationship to Patient: _____
 Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

- I understand that I will be billed \$35.00 for all returned checks to cover any associated bank fees.
- I understand that if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I understand that I will be responsible for any additional charges or fees necessitated by the collection agency or attorney, including reasonable attorney's fees.
- If you are unable to keep your appointment, please inform us at least 24 hours in advance so we may make that time available for someone else. **I understand that I will be billed \$50 for an appointment cancellation done within a 24-hour period or a no-show appointment.**
 If you are more than **15 minutes** late, you will be asked to reschedule. *If you do not show for your scheduled appointment two times, you will be discharged and will not be able to be seen by our provider.*
- I, the patient gives the physician and clinical staff permission to examine, instill eye drops including dilation drops, and administer any testing deemed necessary by the rendering provider.

MESSAGES LEFT ON ANSWERING MACHINES/VOICEMAIL/EMAIL/TEXT

- I give permission to Okaloosa Ophthalmology-Pediatric & Adult Eye Care to leave medical information such as appointment times, referral information and test results on my answering machine/voicemail/email/text at the phone numbers/email address provided on my patient information form.

ELECTRONIC PRESCRIBING NOTICE AND CONSENT

- I have been made aware and understand that this office uses an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and pharmacy. I have been informed and understand that my provider will be able to see information about medication I am already taking, including those prescribed by other providers, while using the electronic system. I give my consent to my provider to see this protected health information.

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____



AI- Assisted Video Scribing Consent

Okaloosa Ophthalmology will be using AI-Assisted Video scribing during appointments. This is to improve the timing and accuracy of completing medical chart notes. This system will record audio of the medical encounter and generate a draft clinical note for review by the provider.

I acknowledge that:

- Access to recordings, transcripts, and generated notes is limited to authorized individuals and systems only involved in patient care and documentation.
- The AI scribing vendor is required to safeguard information in accordance with HIPAA.
- Recordings and transcripts automatically delete in 7 days.
- I understand that the physician remains responsible for the final medical record.

By signing below, I consent to the use of AI-Scribing during todays and future visits unless I revoke my consent in writing.

Patient Name: _____ **Date:** _____

Guardian Name (if patient is a minor): _____

Patient/Guardian Signature: _____



Phone: (850) 683-3937 Fax: (850) 683-0227

ADVANCE BENEFICIARY NOTICE (ABN)

You are receiving this notice because your insurance company may consider REFRACTION a non-covered service and therefore may not pay for it.

WHAT YOU NEED TO KNOW

Read this notice so you can make an informed decision about your care.

Ask questions.

WHAT IS A REFRACTION?

Refraction is checking for glasses. Refraction is performed for all new patient exams, complete/annual exams, and for new or unexplained changes in vision. The refraction is considered a non-covered service by Medicare and many insurance companies. If your insurance company does not cover the refraction, \$35.00 will be collected at the time of service.

Supplies and Services	Reason Insurance May Not Pay	Estimated Cost
CPT 92015 REFRACTION	Insurance company may consider this a non-covered service	\$35.00

☐ YES, I want to receive this service if the doctor deems it necessary. If my insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment with my insurance carrier.

☐ NO, I have decided not to receive these services.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Authorization to access records and bring minor to appointments

Name	Relationship to Patient	Phone Number	Can access medical records	Can bring to appt & make medical decisions	Is an emergency contact
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No

- *Medical records may include a variety of information, diagnoses, treatments, and procedures including psychiatric or psychological, drug/alcohol abuse, acquired immune deficiency syndrome (AIDS) and HIV.*
- *With the above indicated person accompanying the patient, Okaloosa Ophthalmology has my permission to treat the patient in my absence, and they will not be held accountable for medical decisions made by the named caretaker on my behalf.*
- *The Permission to Treat is applicable beginning the signed date of this form and effective for the duration of treatment or until revoked by me.*
- *It is the patient/legal guardian's responsibility to immediately notify Okaloosa Ophthalmology of a divorce, legal separation, change in custody arrangements, or any circumstance which may alter this authorization.*

Authorization for examination and treatment of a Minor

- *Legal guardian MUST provide clinic with legal guardian paperwork prior to minor patient being seen.*
- *I attest that the information is correct and that I am the PARENT/LEGAL GUARDIAN of the patient.*
- *I, the parent/legal guardian, give the physician and clinical staff permission to examine, instill eye drops including dilation drops, and administer any testing deemed necessary by the rendering provider.*

Notice of Privacy Practices: Acknowledgement

A copy of this facility's Notice of Privacy is available. As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), by signing below I acknowledge that I was provided a copy of the facility's Notice of Privacy Practices upon request.

Authorization and Release

I authorize payment of insurance benefits directly to Okaloosa Ophthalmology. I understand and agree to allow Okaloosa Ophthalmology to use its Patient Health Information (PHI) for treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of ophthalmology care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that co-pay, co-insurance, and deductibles are due AT TIME OF SERVICE.

By signing below, I hereby acknowledge that I have read, understand, and agree to each of the policies listed above.

Patient's Name: _____

Patient's Signature: _____ Date: _____ Time: _____

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____ Time: _____

This authorization may be amended or revoked at any time upon receipt of a written request.

Dr. Tiffany Kruger

100 Price-Gregory Way

Crestview, FL 32536

Phone: (850) 683-3937 Fax: (850) 683-0227

Email: Okaloosaophthalmology@gmail.com



AUTHORIZATION TO RELEASE MEDICAL RECORDS

The facility/agency authorized to RELEASE my health information is:

() Okaloosa Ophthalmology / Dr. Tiffany Kruger

() Other: _____

The facility/agency authorized to RECEIVE my health information is:

() Okaloosa Ophthalmology / Dr. Tiffany Kruger

Please send records to:

() 100 Price-Gregory Way, Crestview, FL 32536

() Fax (850) 683-0227

() Email: Okaloosaophthalmology@gmail.com

() Other: _____

Health information that may be used/disclosed is limited to the following:

() All records

() Other: _____

Health information that may be used/disclosed is limited to the following treatment dates:

(a) Unlimited

Health information to be released to Okaloosa Ophthalmology will be used for the following purpose:

(a) Continuation of care

I hereby discharge the releasing facility, its agents, and its employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorize encounter, to include alcohol, drug abuse, communicable diseases including HIV status, and/or psychiatric diagnosis compiled during my visit, encounter or hospitalization, or to make copies in accordance with HIPAA regulations and with the policies of Okaloosa Ophthalmology Pediatric & Adult Eye Care.

Print patient name

Patient's date of birth

Patient / legal guardian signature

Today's date