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		Thyroid disease
	High blood pressure		Other:
	High cholesterol		Other:

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

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

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

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 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.

☐ OTHER. Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

Patient's Name: ______________________ DOB: ____________

Patient's Signature: ______________________ Date: ____________

Parent/Legal Guardian's Name(s): ______________________

Parent/Legal Guardian's Signature: ______________________ Date: ____________

Please Print Clearly

Name:_______________________________ Referred By: ___________________________
Date of Birth: ___________________________ PCP (Full name) : _______________________
Address: _______________________________ PCP Phone number: ______________________
City: ______________State:______Zip:______ Email Address: _________________________
Home Phone: ___________________________ Male: __________ Female: _______________
Cell Phone: ____________________________ Social Security Number: _________________

INSURANCE INFORMATION

Primary Insurance: _______________________ Secondary Insurance: ____________________
Name on Insurance Card: __________________ Name on Insurance Card: ________________
Sponsors 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 that 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 my 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 my 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.

Signature of Patient/Responsible Party of Patient: ______________________________
Relationship to Patient: _________________________ Date: ___________________

4100 S Ferdon Blvd. Ste C2 Crestview, FL 32536 Ph # 850-683-3937 Fax # 850-683-0227

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

- *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 decision made by the name caretaker on my behalf.*
- *This 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 other 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(s): ____

Parent/Legal Guardian's Signature: __________________________ Date:__________ Time: ________

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

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

( ) Okaloosa Ophthalmology / Dr. Tiffany Kruger
4100 S. Ferdon Blvd., Suite C2, Crestview, FL 32536 Ph# (850) 683-3937 Fax# (850) 683-0227
( ) Other: ____

____

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

( ) Okaloosa Ophthalmology / Dr. Tiffany Kruger
4100 S. Ferdon Blvd., Suite C2, Crestview, FL 32536 Ph# (850) 683-3937 Fax# (850) 683-0227
( ) Other: ____

____

Health information that my may be used/disclosed is limited to the following:
( ) All records
( ) Other: ____

Health information that may be used/disclosed is limited the the following treatment dates:
(X) Unlimited

Health information to be released to Okaloosa Ophthalmology Pediatric & Adult Eye Care will be used for the following purpose: Continuation of care and medical treatment

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

__________________________ __________________
Print patient name Patient date of birth

__________________________ __________________
Patient / legal guardian signature Date