

**EYE CENTER OF
ST. AUGUSTINE
(904) 829-2286**

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION	INSURANCE
<p style="text-align: right;">Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p style="text-align: center;">City _____ State _____ Zip _____</p> <p>Sex: <input type="checkbox"/> M <input type="checkbox"/> F Race _____</p> <p>Age & Birthdate _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient SS# _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Employer Address _____</p> <p>Employer Phone _____</p> <p>Spouse's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Spouse's Occupation _____</p> <p>Spouse's Employer _____</p> <p>Whom may we thank for referring you? _____</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Subscriber Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>ASSIGNMENT AND RELEASE</p> <p>I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p>_____</p> <p>Responsible Party Signature</p> <p>_____</p> <p>Relationship _____ Date _____</p>

PHONE NUMBERS
<p>Home _____ Work _____ Ext _____ Spouse's Work _____</p> <p>Best time and place to reach you _____</p> <p>IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)</p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Work Phone _____</p> <p>Do you have advanced directives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

EYE HEALTH HISTORY																																																					
<p>Date of last eye exam _____</p> <p>Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> All the time <input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV</p> <p>Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type _____ Hours/Day _____</p> <p>Describe any problems you have with your contacts _____</p>	<p style="text-align: center;">Place a mark on "Yes" or "No" to indicate if you have had any of the following:</p> <table style="width:100%; border: none;"> <tr> <td>Bloodshot Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Glaucoma</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Headaches</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Burning Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Itching Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cataracts</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Light Sensitive</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Color Vision, Poor</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Loss of Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Crossed Eyed</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Migraine Headaches</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Discharge from Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Night Vision, Poor</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Double Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Red Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dry Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Halos</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Infection</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Flashes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Injury</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Temp. Loss of Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Fainting Spells, Blackouts</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Twitching Eyelid</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Floater or Spots</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Watering Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Color Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temp. 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HEALTH HISTORY

Family Physician _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following since your last visit. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____		
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently or have you ever taken Flomax? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol use _____		
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Date _____

MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy Name _____

Pharmacy Phone # _____

ALLERGIES

List your allergies to medications or other substances:

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Eye Center of St. Augustine for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary

Date