GAINESVILLE OPHTHALMOLOGY

NEW PATIENT FORM

NAME (LAST) _____ (FIRST) _____MI_____

ADDRESS _____CITY_____ST_____ZIP_____

HOME PHONE #_____CELL PHONE #_____

DATE OF BIRTH _____ AGE _____ SEX: MALE / FEMALE

SOCIAL SECURITY # _____ ETHNICITY: HISPANIC/NON-HISPANIC/UNKNOWN

RACE: ASIAN / BLACK AFRICAN AMERICAN / WHITE /NATIVE HAWAIIAN / PACIFIC ISLANDER / OTHER

MARITAL STATUS_____ LANGUAGE_____

EMPLOYER_____WORK PHONE #_____

NAME OF SPOUSE OR PARENT (IF MINOR) _____

SPOUSES OCCUPATION/EMPLOYER _____ _____

EMERGENCY CONTACT_____ PHONE # _____

REFERRING PHYSICIAN_____ PHARMACY_____

INSURED'S NAME_____INSURED DATE OF BIRTH_____

PRIMARY INS_____ ID#_____

SECONDARY INS _____ ID# _____

NAMES OF FAMILY MEMBERS WE'VE SEEN _____

********** PATIENT CONFIDENTIALITY **********

THE FOLLOWING PERSON (S) HAS AUTHORIZATION TO DISCUSS MY MEDICAL RECORDS OR CONDITION WITH YOUR OFFICE PERSONNEL AND MAY BE USED AS AN EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PRIVACY NOTICE:
I HAVE RECEIVED THE GAINESVILLE OPHTHALMOLOGY PRIVACY STANDARDS NOTICE OF HEALTH INFORMATION PRACTICE.

SIGNATURE_____ DATE_____

GAINESVILLE OPHTHALMOLOGY

HEALTH HISTORY

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

MEDICAL HISTORY Have you been diagnosed with any of these conditions in the past?

YES	NO	
___	___	Cancer (Type: _____)
___	___	COPD
___	___	Coronary Artery Disease (Heart Attack)
___	___	Diabetes (Number of years: _____)
___	___	Hypertension (High blood pressure)
___	___	Stroke
___	___	Thyroid Disease (Hypo ___ or Hyper ____)
___	___	Autoimmune Disease (Type: _____)
___	___	Other (please list)

_____
_____
_____

SOCIAL HISTORY

Smoking History:
_____ Never
_____ Previously. Quit date _____
_____ Current. _____packs/day

DRUG ALLERGIES

_____
_____
_____
_____

YOUR EYE HISTORY Have you been diagnosed with any of these conditions in the past?

YES	NO	
___	___	Cataracts Surgery? R ____ L____
___	___	Corneal Disease R___ L___
___	___	Diabetic Damage R___ L___
___	___	Glaucoma R___ L___
___	___	Macular Degeneration R___ L___
___	___	Retina Hole/Tear/Detach R___ L___
___	___	Other eye diseases/surgeries

_____
_____
_____

FAMILY HISTORY Has anyone in your family had any of the following?

YES	NO	
___	___	Blindness
___	___	Cataract
___	___	Corneal Disease
___	___	Glaucoma
___	___	Macular Degeneration
___	___	Retinal Detachment

MEDICATIONS YOU ARE CURRENTLY TAKING Please include over the counter medicines.

_____
_____
_____
_____
_____
_____
_____
_____

GAINESVILLE OPHTHALMOLOGY

PATIENT FINANCIAL POLICY

CO-PAYS, CO-INSURANCE, DEDUCTIBLES, REFRACTIONS, CONTACTS AND NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE.

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS OR ANY OTHER RELATED INSURANCE CLAIM.

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION TO OTHER PHYSICIANS OR LABORATORIES RENDERING SERVICES.

I HAVE BEEN ADVISED THAT THERE IS A POSSIBILITY THAT SOME SERVICES MAY BE DENIED AS "NOT MEDICALLY NECESSARY" OR NON-COVERED SERVICES.A REFRACTION IS A NON-COVERED SERVICE BY YOUR INSURANCE COMPANY. I ACKNOWLEDGE AND ACCEPT LIABILITY FOR FULL PAYMENT FOR THE PRESENT AND FUTURE SERVICES, REGARDLESS OF MY INSURANCE CARRIER'S PAYMENT.

_____ _____

SIGNATURE (GUARDIAN – IF MINOR) DATE

_____ _____

PRINTED NAME IF MINOR, RELATIONSHIP