

TALLAHASSEE EYE CENTER

PATIENT INFORMATION

Date: _____

Name: _____ Gender: M / F Date of Birth: ____ / ____ / ____
 First MI Last

Address: _____ City: _____ State: _____ ZIP: _____

Phone Numbers: Home: _____ Cellular: _____ Work: _____

E-Mail: _____ SS#: _____ - _____ - _____

What is the best way to contact you? Home Cellular Work E-mail Mail Other _____

Race: (please circle) White / Black (African American) / Asian / Multiracial / Hispanic / Other _____

Ethnicity: Hispanic (Latino) / Not Hispanic (Latino) / Native Hawaiian or Pacific Islander Preferred language: English / Spanish

Occupation: _____ Employer: _____

Spouse's Name: _____ Dependent Children's Name(s): _____

Person to contact in case of emergency: _____ Phone: _____

How did you hear about our office? _____

INSURANCE INFORMATION (please bring all insurance cards to receptionist)

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____

AUTHORIZATIONS

I acknowledge that I have received a copy of Tallahassee Eye Center's Notice of Privacy Practices.

Patient Signature: _____ Date: _____

I authorize the release of any medical information necessary to process insurance claims to my insurance company and/or any other physician or health care provider that may be involved in my care. I authorize and request my insurance company to remit payment of benefits directly to Tallahassee Eye Center. I further understand that I am responsible for payment for all services rendered including those services that may not be covered by my insurance company. This authorization is to be valid until otherwise revoked in writing.

Patient Signature: _____ Date: _____

The doctors at Tallahassee Eye Center routinely dilate the pupils of the eyes in order to obtain a thorough view of the interior structures of the eye. Without pupil dilation, the doctor will not be able to completely evaluate your eye health and may not detect certain diseases and disorders. Pupil dilation usually results in blurry near vision and increased light sensitivity for 3 to 6 hours. Although most patients have minimal effect upon their distance vision and feel comfortable driving after dilation, it is possible that you may not see well enough to drive safely. It is your responsibility to make arrangements to be transported by other means if you feel that your vision is too blurry to drive safely following dilation. It is also your responsibility to notify the doctor and staff if you do not wish to have your eyes dilated or would prefer to reschedule the dilation.

I have read and understand the above statement regarding pupil dilation.

Patient Signature: _____ Date: _____

MEDICARE

◆ COVERAGE OVERVIEW

For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits, tests and materials. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary. You are also responsible for a deductible and certain non-covered fees, as described below. Our office may elect to 1) bill you directly for your portion of the fees, or 2) bill your **supplemental insurance**, if you carry it.

◆ MEDICARE HMO PLANS

Tallahassee Eye Center is **not** a provider for any Medicare HMO plans (Advantage Plus, Universal, etc.) with the exception of Medicare Humana Gold. If you are a participant with any of these plans, you will be responsible for payment for your services and materials. We will be happy to provide you with the paperwork you will need to supply your insurance company for any appropriate reimbursement.

◆ DEDUCTIBLE

Medicare has a yearly deductible (\$162 in 2011) that takes effect each January and may change from year to year. If our office is the first to submit a Medicare claim for you in the current calendar year, Medicare will notify you that you have not met your deductible for the year. Medicare will not pay for your allowable fees until the deductible is met.

◆ EXCEPTIONS, NON-COVERED SERVICES & MATERIAL FEES

- ◆ Medicare does not pay for refractive services. This is the part of your eye exam that determines your prescription for eyeglasses. It is typically performed on a yearly basis.
- ◆ Medicare will not pay for any services unless there is a medical reason for the visit. Preventative medical services and screenings are not covered by Medicare. If your exam is purely "routine" (to determine your eyeglasses prescription and screen for eye disease) and no separate medical diagnosis is made, Medicare will not cover any fees for that visit.
- ◆ Medicare does not cover glasses or contact lenses unless you have had cataract surgery. If you have had cataract surgery, Medicare will cover a portion of the cost of your eyeglass lenses and one standard frame one time per operation. Any additional lens options or frame upgrades are your responsibility.

◆ AUTHORIZATION STATEMENT/SIGNATURE

I have read and understand the information above and agree to pay for any services and materials I order, but which are not covered by Medicare.

Patient/Beneficiary Signature _____ Date _____

◆ LIFETIME INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for the insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Tallahassee Eye Center on my behalf for any services and materials furnished. I authorize and holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature _____ Date _____

Screening Retinal Photography

Tallahassee Eye Center is now offering a new, computerized digital camera that allows us to provide you with a more thorough medical analysis of your eye health. This digital retinal imaging system takes high resolution photographs of your retina (the back of your eye) to assist your doctor in the early detection of many disorders including cataracts, macular degeneration, glaucoma, diabetic retinopathy and many other conditions. These images are stored in the computer and will be compared with images acquired during future exams to allow the doctor to observe even the smallest change from the previous exam.

Screening retinal photography is strongly recommended for:

- Patients who are new to our practice
- Patients who have never had retinal photos in this office (we recommend screening retinal photography every 1 to 3 years depending on risk factors)
- Patients over 65 years of age
- Patients with a family history of diabetes, high blood pressure, glaucoma or macular degeneration
- Patients who have vision that is not correctable to 20/20 in one or both eyes

The fee for screening retinal photography is \$28, and is not typically covered by your insurance. Dilation is usually not required to obtain screening retinal photographs.

_____ **YES, I want this procedure**

_____ **NO, I do not want this procedure**

Signature

Print name

Date

Extended Retinal Photography

We also are able to perform extended retinal photography for patients with certain eye conditions.

Extended retinal photography is strongly recommended for:

- Patients with ocular conditions such as glaucoma, diabetic retinopathy, macular degeneration and others. Your doctor will advise you if you need extended retinal photography.

The fee for extended retinal photography is \$79 and is typically covered by your medical insurance after all deductibles and co-payments have been made.

MEDICAL HISTORY

Please Print

Patient's Name _____

Date ____ / ____ / ____

Ocular History

Date of Last Eye Exam: _____ Who was your prior eye doctor? _____

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Brand and power of current contact lenses: _____

If you do not already wear contacts, are you interested in wearing contact lenses? Yes No

Have you ever been diagnosed with any of the following?

Disease/Condition	NO	YES
Cataracts		
Glaucoma		
Diabetic retinopathy		
Eye Injury		

Disease/Condition	NO	YES
Dry eye		
Corneal disease		
Retinal disease		
"Lazy" eye - amblyopia		

Additional information:

Please list any prior eye surgeries (including dates):

Please list any eye-related medications (including over-the-counter) that you use:

Medical History

Primary Care Provider _____ Last Visit ____ / ____ / ____ Phone (____) _____

Are you pregnant and/or nursing? No Yes

Do you have any allergies to medications? No Yes If yes, explain:

Have you ever been diagnosed with any of the following?

Disease/Condition	NO	YES
High blood pressure		
Heart disease		
Diabetes		
Breathing problems		

Disease/Condition	NO	YES
Rheumatoid Arthritis		
Lupus		
Thyroid disorder		
Cancer		

Disease/Condition	NO	YES
Infectious disease		
Kidney disease		
Liver disease		
Other _____		

List all major injuries, surgeries and/or hospitalizations you have had:

Medications (include dosages):

Social History

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	NO	YES	?	Relationship to You
Blindness				
Crossed Eyes				
Cataract				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Heart Disease				
High Blood Pressure				
Diabetes				
Other				

Review of Systems

Current Vital Signs: Height: _____ Weight: _____

Do you currently have any problems in the following areas?

	NO	YES	?
Allergic			
Environmental allergies			
Cardiovascular			
Chest pain/pressure			
Irregular heartbeat			
Constitutional			
Fevers			
Unexplained weight loss/gain			
Ear, Nose, Throat			
Dry throat/mouth			
Chronic congestion			
Hearing loss			
Endocrine			
Blood sugar variations			
Excessive thirst/urination			
Eyes			
Blurred vision			
Loss of vision			
Double vision			
Dryness			
Itching			
Sandy/gritty/foreign body sensation			
Excessive watering/tearing			
Discharge			
Glare/light sensitivity			
Eye pain/soreness			
Chronic eye infection			
Flashes			
Floaters			

	NO	YES	?
Gastrointestinal			
Nausea/vomiting			
Diarrhea/constipation			
Abdominal pain			
Genitourinary			
Urinary difficulties			
Hematologic			
Unusual bleeding			
Easy bruising			
Immunologic			
Autoimmune disorder			
Infectious disease			
Integumentary			
Skin lesions/rashes/mass			
Changes in skin pigmentation			
Musculoskeletal			
Unexplained muscle/joint pain			
Neurological			
Stroke			
Seizure			
Numbness/tingling			
Psychiatric			
Anxiety			
Depression			
Mood swings			
Respiratory			
Shortness of breath			
Chronic cough			

If you answered YES to any of the above or have a condition not listed, please explain:
