Florida Eye Group

**Thank you for choosing our office:**
In order to serve you properly we will need the following information. (Please Print) All information will be strictly confidential.

**Patient Information:** **Date: ____/____/____**

☐ Dr. ☐ Mr. ☐Mrs.☐Miss. Single☐ Married☐ Widowed☐ Divorced ☐

Name: _____ DOB: _____/_____/_____ Age: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Number: _____ Cell Phone: _____

Business Phone: _____ Email: _____

S.S. Number: _____ Occupation: _____

Name of Employer: _____ Phone Number: _____

Spouse/ Parent Name: _____

Emergency Contact: _____ Phone Number: _____

Referred By: _____

Primary Physician: _____ Phone Number: _____

**Insurance Information:**

Primary Insurance Plan (or Medicare #): _____

ID Number: _____ Group Number: _____

Secondary/Supplement Insurance Plan: _____

ID Number: _____ Group Number: _____

**Medical Information:**

When was your last Eye Exam? _____ With Dr.?_____

Do you wear glasses? Yes _____ No _____ Do you wear Contacts? Yes _____ No _____

What is the reason for today's visit? _____

_____

How long have you had this problem? _____



Patient Initials_____

Please list all previous surgeries: _____

_____

Please list all medications or vitamins that you take: _____

_____

_____

Do you use any eye drops? If yes, what? _____

_____

Are you allergic to any Medications? If yes, what? _____

Please **circle** Yes or No for any conditions you have:

| | |
|---|---|
| Heart Failure | Yes No |
| Heart Disease | Yes No |
| Chest Pains | Yes No |
| High Blood Pressure | Yes No |
| High Cholesterol | Yes No |
| Heart Defect | Yes No |
| Heart Surgery | Yes No |
| Pace Maker | Yes No |
| Blood Transfusion | Yes No |
| Anemia | Yes No |
| Sickle Cell Anemia | Yes No |
| Hemophilia | Yes No |
| Leukemia | Yes No |
| HIV | Yes No |
| Stroke | Yes No |
| Hearing Loss | Yes No |
| Earaches | Yes No |
| Migraines | Yes No |
| Dizzy Spells | Yes No |
| Epilepsy | Yes No |
| Psychiatric Treatment | Yes No |
| Brain Injury | Yes No |
| Cancer | Yes No |
| Diabetes | Yes No |
| Thyroid | Yes No |
| Skin Rash or Hives | Yes No |
| Arthritis | Yes No |
| Gout | Yes No |
| Artificial Joint | Yes No |

| | |
|---|---|
| Fever Blisters | Yes No |
| Stomach Ulcers | Yes No |
| Hepatitis | Yes No |
| Cirrhosis | Yes No |
| Crohn's Disease | Yes No |
| IBS | Yes No |
| Organ Transplant | Yes No |
| Reflux Disease | Yes No |
| Hay Fever | Yes No |
| Sinus Problems | Yes No |
| Asthma | Yes No |
| Bronchitis | Yes No |
| Emphysema | Yes No |
| Tuberculosis | Yes No |
| Kidney Stones | Yes No |
| Bladder Problems | Yes No |
| Dialysis | Yes No |
| Drink Alcohol | Yes No |
| Smoke | Yes No |
| Pregnant | Yes No |

Please list any general health problems of your immediate family: _____

_____

_____

_____

_____

_____

_____

Patient's Signature: _____ Date: ____/____/____



Revised 02/09/2011

Florida Eye Group

# SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, INSURANCE INFORMATION AND FINANCIAL AGREEMENT

Patient's Name: _____ Date: ____/____/____
Patient's Date of Birth: ____/____/____

**MEDICARE:** I request that payment of authorized Medicare benefits be made to BENAIM EYE, LLC on my behalf for services furnished to me. I authorize the holder of any medical or financial information about me to release to Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical and financial information necessary to pay the claim(s). If other health insurance is indicated as a Secondary Insurance (item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. BENAIM EYE, LLC accepts the charge determination of Medicare and I am responsible for co-insurance, deductibles and non-covered services.

**INSURANCE:** I request that payment of authorized benefits be made on my behalf to BENAIM EYE, LLC for services furnished to me. I authorize the holder of any medical or financial information about me to release to my insurance company and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical and financial information necessary to pay the claim(s).

**FINANCIAL AGREEMENT:** I agree that in return for services provided by BENAIM EYE, LLC, I will pay my account at the time service is rendered or will make financial arrangement satisfactory to the practice. A photocopy of this authorization shall be considered as effective and as valid as the original. If my account is sent to collection or an attorney for non-payment, I agree to pay collection expenses and attorney's fees. Most insurances require payment of co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services.
**I understand that I am primarily responsible for the payment of any services not covered by Medicare, Medicaid or my Insurance.**

_____ ____/____/____
Patient's Signature or Authorized Party Date

If Authorized Party, Print Name and describe the authority to act: _____
_____
_____

2055 Military Trail, Suite 307, Jupiter, Florida 33458
Phone: 561-747-7777 Fax: 561-575-1921

Revision: 02/09/2011

Florida Eye Group

# Authorization to Use or Disclose Health Information

Name: _____

Date of Birth _____/_____/_____

I understand that as a part of my healthcare, BENAIM EYE, LLC, originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctor and staff of Benaim Eye, LLC are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any time by sending a written request to the BENAIM EYE, LLC, at 2055 Military Trail, Suite 307, Jupiter, FL 33458, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.

I acknowledge that by my signing below, I have had full opportunity to read and consider the contents of this consent form. I am giving my permission for use and disclosure of my PHI to carry out treatment, payment activities and healthcare operations.

This authorization shall expire seven years after my last day of service.

_____ _____/_____/_____

Signature of Patient or Authorized Representative Date

If signed by the Patient's Authorized Representative, please print the name and describe the representative's authority to act for you.

Representative's Name_____

Representative's Authority_____

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Revision: 02/09/2011

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## *Patient Vision and Life Style Questions*

Thank you for selecting our practice for your vision exam and treatment, we want to help you maintain excellent vision as an important step in understanding how you use your eyes on a daily basis. We ask you to answer the brief questions below. Please check all that apply in how you use your eyes, we will be reviewing this during your visit.

Print name: _____ Date: _____

If employed, what is your occupation? _____

Do you mind wearing glasses? Yes _____ No _____

Do you have difficulty with any of the following activities?

___ reading, sewing, or other near activities?
___ seeing/reading road signs at a proper distance
___ recognizing faces or seeing the clock across the room
____ working on computer
____ reading shopping labels

Have you experienced any of the following?

___ halos, glare, or difficulty seeing at night
___ difficulty with depth perception
____ difficulty with color perception
____ overall decrease in vision

What activities do you enjoy or do frequency?

___ reading
___ sewing
___ playing cards
___ computer
___ painting
___ cooking
___ watching TV
___ driving
___ watching/playing Sporting events

List your 3 favorite hobbies or work activities: Amount of time spent per day on any of these activities:

1. _____ _____
2. _____ _____
3. _____ _____

Where do you hold your reading material? ___ Arm Length ___1/2 Arm's Length ___ 8-10 inches

What kind of light do you use when reading? ___ Dim ___ Bright Overhead Light ___ Lamp off to the side