

If we are accepting your insurance, please complete the following insurance information:

INSURED'S NAME: SELF OTHER: _____
Last First M.I.

RELATIONSHIP OF INSURED TO YOU: SELF OTHER (your wife, father, etc.): _____

INSURED'S BIRTHDATE: ___/___/___ **INSURED'S EMPLOYER:** _____

INSURED'S ID# _____ **GROUP#** _____

ULTIMATE RESPONSIBILITY OF PATIENT OR LEGAL GUARDIAN FOR PAYMENT OF FEES: Fees are due when services are rendered and products are ordered, unless prior arrangements have been made. *Arrangements for accepting pre-approved insurance plans MUST be made in advance, and all deductibles and/or co-pays MUST be paid on the day of service.* For your convenience, we accept cash, personal checks, MasterCard®, Visa®, and Discover®.

If insurance is being accepted for services rendered, I authorize the release of any information necessary, including any information acquired in the course of my examination, to determine responsibility for payment and to obtain reimbursement. I hereby authorize the payment of any insurance benefits otherwise payable to me directly to Eye Associates of Winter Park. Any overpayments will be promptly refunded.

I understand that I or my legal guardian am ultimately responsible for all services and products rendered and dispensed by Eye Associates of Winter Park, *even if* Eye Associates of Winter Park accepted my insurance. If Eye Associates of Winter Park has not received payment in full (according to any payment schedule previously approved by the insurance carrier and/or previously agreed to by Eye Associates of Winter Park) by 90 days from the date of service, I understand that it will be my or my legal guardian's responsibility to immediately pay any outstanding, undisputed balance and if insurance coverage is involved, to pursue any reimbursement from the insurance company myself. Any outstanding balance not paid after 90 days may be turned over to a collection agency, and any fees associated with the collection of outstanding balances over 90 days will be my or my legal guardian's responsibility.

Personal Health Information Privacy

How may our office contact you? Please check all acceptable ways:

- Home phone, direct contact Home answering machine/voice mail Work phone, direct contact
 Work phone, voice mail Work phone, leaving a message with co-worker/employee
 Regular mail E-mail at _____

What information may we give when we contact you? Please check all acceptable information:

- Confirming appointments Referral Information Prescription Refills Test Results
 Glasses or contact lens orders Other _____

Who of your family and/or friends may we discuss information regarding your treatment and care? Please list:

I understand and accept all of the above. I am aware of and acknowledge the Eye Associates of Winter Park "Notice of Privacy Practices" posted in the office. I certify that the information provided on this form is true and correct.

X _____
Patient or Guardian Signature

Date

MEDICAL HISTORY QUESTIONNAIRE

Information asked for below is required by Medicare and medical insurance plans. **All information is private and confidential & will not be released to anyone except by written authorization from you or your legal guardian.**

Date: ___/___/___ Mr. Mrs. Ms. Miss Dr.

Name: _____ Date of Birth: ___/___/___

Primary Care Physician: _____ Physician's Telephone: (_____) _____

Emergency contact person and telephone number: _____

Any medication allergies? [None] _____ Are you pregnant?: Yes No N/A

Current eye medications: [None] _____

Current non-eye medications: [None] _____

Eye surgical procedures & dates: [None] _____

Non-eye surgical procedures & dates: [None] _____

Date of last complete eye examination: ___/___/___ Date of last complete medical physical: ___/___/___

**Do you or any blood-related family members have or have had any of the following?
Please explain "YES" answers below, including the date of diagnosis for any of your
diseases or problems, and *who* in your family has/had any diseases or problems:**

<u>SELF</u>	<u>FAMILY</u>	
Y N	N/A	Eye injuries _____
Y N	Y N	Eye surgery _____
Y N	Y N	Loss of vision _____
Y N	Y N	Glaucoma _____
Y N	Y N	Macular degeneration _____
Y N	Y N	Cataracts _____
Y N	Y N	Retinal detachment _____
Y N	Y N	Diabetic eye disease _____
Y N	Y N	Amblyopia (healthy eye NOT seeing 20/20 <u>WITH</u> glasses) _____
Y N	Y N	Strabismus (an eye turning in, out, up, or down) _____
Y N	Y N	Legal blindness (<u>WITH</u> glasses) _____
Y N	Y N	Any other eye diseases _____
Y N	Y N	Seasonal or general allergies _____
Y N	Y N	Rheumatoid arthritis, lupus, other autoimmune diseases (circle) _____
Y N	Y N	Heart disease, high blood pressure, chest pain (circle) _____

