EYE PHYSICIANS of FLORIDA
Exceptional Eyecare for the 21st Century

Advanced Eye Surgeons
Registration Form

Name: _____ **Date:** _____

Address: _____
Street *City* *State* *Zip Code*

SSN: _____ **DOB:** _____ **Age:** _____ **Sex: M / F**

***Cell Phone Number:** _____ **Work Number:** _____

Home Number : _____ ***** **Email:** _____

Employer: _____ **Occupation:** _____

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Widow/Widower**

Language: □ **English** □ **Spanish** □ **Other** _____

Emergency Contact: _____ **Phone Number:** _____

Primary Care Doctor: _____ **Tel Number:** _____

***** **Would you like your medical notes to be sent to your Primary Doctor?*** □ **YES** □ **NO**

Referring Doctor: _____ **Tel Number:** _____

Pharmacy: _____ **Tel:** _____ **Address:** _____

I have read and accept Advanced Eye Surgeons Policy, which insures that my medical records will be released only to my Insurer, and authorize the release of medical information to them in order to determine benefits. I request the payment of authorized insurance benefits be made on my behalf to Advanced Eye Surgeons for any services provided. I understand that my records will not be released to anyone else without my written authority.

_____ _____

Patient Signature/Legal Guardian Signature Date

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

MEDICAL HISTORY

Medical/Ocular History: (Please mark all that apply)

□ **Overall Healthy**	□ Cataract	□ Graves Disease	□ Hypertension	□ Sjogren's Disease
□ Allergies	□ Cholesterol	□ Headache/Migraine	□ Liver Disease	
□ Anxiety	□ Depression	□ Hearing Loss	□ Lasik/PRK	
□ Arthritis	□ Diabetes	□ Heart Disease	□ Lupus	
□ Rheumatoid Arthritis	□ Dry eye	□ Hepatitis	□ Macular Degeneration	
□ Asthma	□ Eczema	□ Herpes	□ Pituitary Tumor	□ Thyroid Disease
□ Cancer	□ Glaucoma	□ HIV/AIDS	□ Skin Cancer	□ Stroke

Other _____

MEDICATIONS

List all prescription medications:

_____ _____ _____

_____ _____ _____

Any allergies to medicine? □ NO □ YES

If yes, what are you allergic to: _____

SOCIAL HISTORY: (Please mark all that apply)

Smoking: □ current everyday smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes how much and how often? _____

Caffeine Use: □ No □ Yes If yes how much and how often? _____

FAMILY HISTORY: (Please mark all that apply)

CONDITION	Relation (EX:Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)
□ **Diabetes**	
□ **Glaucoma**	
□ **Macular Degeneration**	
□ **Hypertension**	
□ **Cancer/Type of Cancer**	

_____ _____ _____

Patient Signature Archana Gupta, MD Date

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Patient Name: _____ DOB: _____
(please print)

Patient Demographics Questionnaire

We are asking for your race and ethnicity because some people have higher risks of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly. We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care. Thank you! **We greatly appreciate your participation!**

1. Race. Please mark the statement(s) that best describes you

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ I prefer not to answer

2. Language. Please indicate your preferred spoken language.

☐ English
☐ Other: _____
☐ Spanish
☐ I prefer not to answer

3. Ethnicity. Please mark the <u>ONE</u> statement that best describes you.

☐ Hispanic or Latino
☐ Unknown
☐ Not Hispanic or Latino
☐ I prefer not to answer

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DILATION POLICY

This signed affidavit will serve as proof that you have been duly advised that your vision may be temporarily impaired following your eye examination today or during subsequent visits to our office.

Dilating drops may be used during the course of your examination to aid in the diagnosis and treatment affecting the eyes. The use of these drops as well as other methods of examination and treatment may render your vision blurred for a variable period of times thus interfering with your ability to safely operate a motor vehicle. Whenever possible, you should come to the office with a driver or you should wait in our office until your vision returns to normal. If necessary, our office can assist you in arranging for alternative transportation.

By signing this document, I am releasing Dr. Archana Gupta and staff from any liability as a result of injury to myself or injury I may inflict upon others relating to the status of vision following any further eye examination and treatment rendered today or following any further eye examinations and treatment.

Signature: _____ Date: _____

Print: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this form, you acknowledge that you have the option to request a copy of our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices

_____ _____
Patient's (or Legal Representative's) Signature Date

_____
Relationship of Legal Representative

For office use only

To be completed only if Acknowledgment is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?

[ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgment and our efforts to try to obtain the patient's signature:

_____
_____
_____

_____ _____
Name/Title Date

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REFRACTION SERVICE AND FEE

Refraction is the optical determination of the best possible corrected vision. It is the test done to determine, and therefore provide a prescription for glasses. It is also needed to determine if any medical, optical or surgical treatment may be indicated. It is a necessary part of the ophthalmic examination, if a prescription is needed to be printed for you, it is NOT a covered service by Medicare or any insurance company. Our office fee for the refraction is $45.00. This fee is collected in addition to any co-payment, co-insurance, or deductible.

Acknowledgement:

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service since it is not covered by my insurance carrier. The copayment, coinsurance, and deductible are separate from, and not included in, the refraction fee.

_____
Name of Patient

_____
Patient Signature (or person authorized to sign for patient)

_____
Date

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Financial Policy

The following information is regarding your account at Advanced Eye Surgeons. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent care for all of your eye care needs.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan since they constantly change. We cannot be held liable for misquoted benefits or eligibility.
- The determination of your best corrected vision is called a **refraction**. If you request a copy of your glasses prescription, this is is considered a **non-covered service/procedure** by all insurance companies. You will be responsible for the **$45.00 fee when a copy of the prescription is given to you.**
- If your insurance requires a referral, you are responsible for contacting your primary care physician to obtain said referral. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- All "self pay" patients are required to pay in full at the time services are rendered.
- Our office does **not** accept insurance liens, workers compensation, or attorney liens. Payment is the patient's responsibility and due in full at the time of service.
- All **returned checks** are subject to a **$35.00** processing fee and will result in refusal to accept future payments by check.
- All outstanding balances must be paid in full before scheduling any surgery.
- All delinquent accounts may be sent to a collection agency and you may be charged any/all applicable collection fees.

I understand that even if Advanced Eye Surgeonsis contracted with my healthcare plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Advanced Eye Surgeons for services rendered and request that Advanced Eye Surgeons submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

_____ _____

Patient Signature/Legal Guardian Signature Date

_____

Please Print Patient's Name

Thank you for choosing Advanced Eye Surgeons!

Advanced Eye Surgeons/ Eye Physicians of Florida, LLP

Date: Name:

Review of Systems:

Please indicate below your ***current*** problems with an "X" in the YES box. If you are not currently experiencing a problem with any of the symptoms listed below, please indicate this by marking an "X" in the NO box.

The patient is instructed to consult with their primary care physician regarding any non-ophthalmic symptom.

CONSTITUTIONAL:

□ NO □ YES Fatigue
□ NO □ YES Fever
□ NO □ YES Night Sweats
□ NO □ YES Weakness
□ NO □ YES Weight Gain
□ NO □ YES Weight Loss

HEAD, EYES, EARS, NOSE AND THROAT:

□ NO □ YES Hearing Loss
□ NO □ YES Ringing in Ears
□ NO □ YES Sinus Problems
□ NO □ YES Sore Throat
□ NO □ YES Vertigo

RESPIRATORY:

□ NO □ YES Asthma
□ NO □ YES Cough
□ NO □ YES Coughing Blood
□ NO □ YES Shortness of Breath
□ NO □ YES Wheezing

CARDIOVASCULAR:

□ NO □ YES Calf Pain
□ NO □ YES Chest Pain
□ NO □ YES Fast Heart Rate
□ NO □ YES Irregular Heartbeat/Palpitations
□ NO □ YES Leg Swelling

GASTROINTESTINAL:

□ NO □ YES Abdominal Pain
□ NO □ YES Decreased Appetite
□ NO □ YES Diarrhea
□ NO □ YES Heartburn
□ NO □ YES Jaundice
□ NO □ YES Nausea
□ NO □ YES Vomiting

Scan as New Patient Forms or Review Of Systems

GENITOURINARY:

□ NO □ YES □ N/A Irregular Periods
□ NO □ YES Painful Urination
□ NO □ YES Urethral Discharge
□ NO □ YES Urgency

METABOLIC/ENDOCRINE:

□ NO □ YES Cold Intolerance

□ NO □ YES Heat Intolerance

NEUROLOGICAL:

□ NO □ YES Headache

□ NO □ YES Lightheadedness

□ NO □ YES Memory Difficulty

□ NO □ YES Numbness of Extremities

PSYCHIATRIC:

□ NO □ YES Depressed Mood

□ NO □ YES Hallucinations

□ NO □ YES Insomnia

SKIN:

□ NO □ YES Hives

□ NO □ YES Rash

MUSCULOSKELETAL:

□ NO □ YES Back Pain

□ NO □ YES Joint Pain

HEMATOLOGIC/LYMPHATIC:

□ NO □ YES Bruising

□ NO □ YES Easy Bleeding

IMMUNOLOGIC:

□ NO □ YES Food Allergies

□ NO □ YES Seasonal Allergies

OTHER:

Reviewed & Date