WELCOME TO TRI COUNTY EYE ASSOCIATES

Palatka Vision Center • St. Augustine Vision Center

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Name:______________________ Date of Birth:__________ Sex: ____M ____F

Address:______________________ SS#:__________

City/State/ZIP:______________________

Phone #:__________ Cell #:__________ Work #:__________

Occupation:__________ Employer:__________

Parent/Guardian Name:______________________

Email:______________________

Race: ❑ White ❑ African American ❑ Asian Primary Language: ❑ English ❑ Spanish ❑ Other

❑ Other__________ ❑ Decline to Answer Special Needs: ❑ Hearing Impaired ❑ Translator ❑ Wheelchair

Marital Status: ❑ M ❑ S ❑ D ❑ W Spouse's Name:__________

Emergency Contact:__________ Phone #:__________ Relationship to Patient:__________

How did you hear about us?__________ Reason for today's visit:__________

Any special concerns/questions?______________________

PRIMARY INSURANCE

Carrier Name:__________ Insurance ID #:__________

Carrier Phone #:__________ Group #:__________

Carrier Address:______________________

Are you the SUBSCRIBER or the DEPENDENT for this plan?__________

Subscriber Name:__________ Relationship:__________

Subscriber DOB:__________ Subscriber SS#:__________

SECONDARY INSURANCE

Carrier Name:__________ Insurance ID #:__________

Carrier Phone #:__________ Group #:__________

Carrier Address:______________________

Are you the SUBSCRIBER or the DEPENDENT for this plan?__________

Subscriber Name:__________ Relationship:__________

Subscriber DOB:__________ Subscriber SS#:__________

SOCIAL HISTORY *This information is kept strictly confidential.*

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes If yes, please describe:__________

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

Have you ever used tobacco products? ❑ No ❑ Yes

If yes, do you CURRENTLY use tobacco products? ❑ No ❑ Yes If yes, type/amount/how long:__________

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

Are you pregnant? ❑ No ❑ Yes Are you breastfeeding? ❑ No ❑ Yes

Hobbies/Recreational Sports you enjoy:__________

-------------------------------FOR OFFICE USE ONLY-------------------------------

Updated By:	Date:	Updated By:	Date:	Updated By:	Date:

Date of last eye exam:________________
Doctor's name:______________________
Do you wear glasses? ❑ Yes ❑ No
❑ All the time ❑ Occasionally
❑ Reading ❑ Driving
How many hours per day do you use a computer? __________
Do you perform fine or close-up work? ❑ Yes ❑ No
Are you outdoors all or part of the time? ❑ Yes ❑ No
Do you have trouble reading signs when driving at night? ❑ Yes ❑ No
Are you bothered by glare from:
Overhead lighting? ❑ Yes ❑ No
A computer screen? ❑ Yes ❑ No
Oncoming headlights at night? ❑ Yes ❑ No
Are you sensitive in bright sunlight? ❑ Yes ❑ No

Do you wear contacts?
❑ Yes ❑ No
Type___________________
Hours/day______________

Please rate your current contact lenses
(1=completely unsatisfied, 10=completely satisfied):
1 2 3 4 5 6 7 8 9 10
Why?
____
Are you interested in refractive surgery? ❑ Yes ❑ No
If you do not currently wear contact lenses, are you interested in learning more about them? ❑ Yes ❑ No

Miscellaneous
List any previous surgeries with dates:
____
____
____

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

	Yes	No
CONSTITUTIONAL		
• Cancer	❑	❑
• Developmental Disabilities	❑	❑
EARS, NOSE, AND THROAT		
• Dry Mouth	❑	❑
• Hearing Loss	❑	❑
NEUROLOGICAL		
• Tumor	❑	❑
• Epilepsy	❑	❑
• Stroke/CVA	❑	❑
• Migraine	❑	❑
• Multiple Sclerosis	❑	❑
PSYCHOLOGICAL		
• Anxiety Disorder	❑	❑
• Depression	❑	❑
• Bipolar Disorder	❑	❑
CARDIOVASCULAR		
• Congestive Heart Failure	❑	❑
• High Blood Pressure	❑	❑
• Heart Disease	❑	❑
• Vascular Disease	❑	❑
RESPIRATORY		
• Sleep Apnea	❑	❑
• Emphysema	❑	❑
• Bronchitis	❑	❑
• Asthma	❑	❑
• COPD	❑	❑

	Yes	No
GASTROINTESTINAL		
• Colitis	❑	❑
• Celiac Disease	❑	❑
• Ulcer	❑	❑
• Crohn's	❑	❑
• Acid Reflux	❑	❑
GENITOURINARY		
• Kidney Disease	❑	❑
• STD (Gonorrhea, HIV, Syphillis, Chlamydia)	❑	❑
MUSCULOSKELETAL		
• Osteoarthritis	❑	❑
• Fibromyalgia	❑	❑
• Arthritis	❑	❑
INTEGUMENTARY		
• Rosacea	❑	❑
• Psoriasis	❑	❑
• Herpes Simplex/Cold Sores	❑	❑
• Eczema	❑	❑
• Herpes Zoster/Shingles	❑	❑

	Yes	No
ENDOCRINE		
• Hyperthyroidism	❑	❑
• Hypothyroidism	❑	❑
• Type 1 Diabetes Mellitus	❑	❑
• Type 2 Diabetes Mellitus	❑	❑
HEMOTOLIGIC/LYMPHATIC		
• Anemia	❑	❑
• High Cholesterol	❑	❑
ALLERGIC/IMMUNE		
• Lupus	❑	❑
• Environmental Allergies	❑	❑
• Rheumatoid Arthritis	❑	❑
• Sjogren's Syndrome	❑	❑
EYES		
• Retinal Hole/Detachment	❑	❑
• Cataract	❑	❑
• Injury	❑	❑
• Glaucoma	❑	❑
• Dry Eye	❑	❑
• Inflammatory Disorder	❑	❑
• Eye Turn	❑	❑
• Macular Degeneration	❑	❑
• Surgery	❑	❑
• Keratoconus	❑	❑
• Sudden Changes in Vision	❑	❑
• Flashes of Light	❑	❑
• Floaters	❑	❑

Family History

Does anyone in your family currently, or have they ever had any problems in the following areas? If yes, who?

	Yes	No	
• Diabetes	❑	❑	______________
• Thyroid Dysfunction	❑	❑	______________
• High Blood Pressure	❑	❑	______________
• Cancer	❑	❑	______________
• Stroke	❑	❑	______________

	Yes	No	
• Retinal Detachment	❑	❑	______________
• Glaucoma	❑	❑	______________
• Macular Degeneration	❑	❑	______________
• Blindness	❑	❑	______________

Today's Date: ____________________

PRESCRIPTIONS, OVER THE COUNTER, AND SUPPLEMENT MEDICATION LIST

Patient Name: ____ DOB: ______________________

Pharmacy Name & Phone #: ____

Drug Allergies: ____

Primary Care Physician & Phone #: ____

DRUG NAME (Please print)	DOSAGE	FREQUENCY	ROUTE (Oral, Nasal, IM, Drops, Topical, Suppository)	ADD / DC DATE

***** If additional space is needed, please print an additional sheet or request one from the front desk *****

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Updated By:	Date:	Updated By:	Date:	Updated By:	Date:

Financial Policy/Insurance Policy:
Our practice participates in many medical insurance plans. If we are participating providers for your plan, we will file the claim on your behalf. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. If your plan requires that you pay a copayment, deductible, or coinsurance, you are required to pay at the time services are rendered. On occasion, we may render a service that is not covered by your insurance plan. We make every effort to inform you of this in advance. Any non-covered services will become due and payable by you upon notice from your insurance carrier. We accept cash, checks, most major credit cards, and Care Credit. Please be sure to provide us with your most current insurance card(s) at each visit and advise us of any changes. All of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service. By signing below you are acknowledging and accepting our financial policy, as well as giving permissions for TRI COUNTY EYE ASSOCIATES to communicate on your behalf to facilitate reimbursement.

Self-Pay Patients: Patients with no insurance are expected to pay at the time of service for all care rendered.

Signature: ____ Date:____________________

Dilation:
I understand that during my exam I may need to have my eyes dilated. I am aware that I have the right to refuse dilation. The following will/may occur: blurry vision for 4-8 hours, light sensitivity, interruption of depth perception, and difficulty driving. I acknowledge this as my informed consent for dilation.

Signature: ____ Date:____________________

Privacy Practice Notice:
We are required by law to maintain the privacy of Protected Health Information and to give you a notice explaining our privacy practices with regard to that information. You have certain rights - and we have certain legal obligations - regarding the privacy of your Protected Health Information. If you would like a copy of the policy that explains your rights and our obligations, please feel free to ask. We are required to abide by the terms of the current version of this policy. By signing, you are acknowledging that you have been informed and that a copy was made available to you.

Signature: ____ Date:____________________

Contact Lens Wearers Only:
I acknowledge that I have been shown to insert, remove, and care for my contact lenses. I agree to clean and disinfect my lenses as directed by my doctor. I understand that contacts are an alternative for glasses and that damage can occur if lenses are not cared for properly. I agree to stop wearing my contacts and seek professional help if I notice: redness, irritation, discomfort, decreased vision, or matted "stuck" lids. I also understand that I am required to have an examination yearly to maintain a current contact prescription and failure to do so may result in refusal of contact lenses.

Signature: ____ Date:____________________