NEW VISION EYE CENTER ~ PATIENT INFORMATION SHEET

PATIENT DEMOGRAPHICS

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different from mailing): _____

Primary Phone: _____ Cell Phone: _____

Patient Employer:_____ Employer Phone: _____

Email Address:_____

Patient Date of Birth: _____ Sex: M or F Marital Status: _____

Patient SS #: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____

The information below is required for Electronic Medical Records:

Pharmacy Name and Location: _____

Preferred Language: _____

Ethnicity: ___ Not Hispanic or Latino ___ Hispanic or Latino

Race: ___ Asian ___ Black or African American ___ White ___ Other

___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander

Which Doctor are you here to see?

___ Dr. Minotty ___Dr. O'Brien ___ Dr. Tate ___ Dr. Reinauer

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Cardholder Name and Date of Birth: _____

(If Minor) Parents Name: _____

Parents Date of Birth: _____ Parents Daytime Phone: _____

How did you hear about us? Please include names.

Our Website _____ Internet Search _____ Radio _____ Other _____

Newspaper _____ Screening _____ Insurance Company _____ TV _____

Referred by M.D. _____

Referred by Optometrist _____

Referred by Friend/Family - Yes or No If yes, whom? _____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Account Number: _____

Date Registered: _____ Registered By: _____

Earning trust, one patient at a time.

NEW VISION EYE CENTER

Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our information privacy official, the Administrator, Lindy MacDonald at 772-257-8700, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information for purposes of requesting your revocation, or you may simply send us a letter in writing. By signing this consent, you acknowledge that you have received a copy of the "Notice of Privacy Policies".

Please list the names of additional people we may disclose your protected health information either by phone or documentation:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

Patient's Signature _____ Date _____

1055 37th Place • Vero Beach, FL 32960 • (772) 257-8700 • Fax (772) 257-8705 • 1-877-MINOTTY • www.NewVisionEyeCenter.com

NEW VISION EYE CENTER

Please read the following Payment Policies before your appointment.

Our office files your insurance as a "courtesy"

If your Doctor is an in-network provider for your insurance,
YOUR COPAY MUST BE PAID AT THE TIME OF SERVICE
ALL DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT.

Please note - Each insurance policy is different. It is your responsibility to know your policy. If pre-authorization is needed, then it is your responsibility to notify our staff so we may obtain authorization. If authorization is not obtained, it is your responsibility to pay for all charges incurred. Remember, your insurance policy is a contract between you and your insurance company. It is not a contract between you and our Doctors. In order for us to process your insurance, we must have a copy of the card. It is also your responsibility to let us know if there is a change in your insurance information.

If you have any questions or are not prepared to pay for your appointment, please notify one of our office staff prior to your appointment. If you are unable to pay for residual balances from previous dates of service you may be asked to reschedule your appointment.

There is a $25.00 charge for NSF checks.

We do not participate with any HMO plans.

***Self pay patients are expected to pay in full at time of service.**

Signature Print Name Date

(By signing this document, I am stating that I have read and understand the above information)

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NEW VISION EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

Please identify which eye surgery you have had, if any: (Please circle yes or no)

Cataract surgery yes/no :Right eye date/doctor _____ Left eye date/doctor _____

Glaucoma surgery yes/no :Right eye date/doctor _____ Left eye date/doctor _____

Retinal surgery yes/no :Right eye date/doctor _____ Left eye date/doctor _____

Vision correction surgery yes/no :Right eye date/doctor _____ Left eye date/doctor _____

Other eye surgery _____ :Right eye date/doctor _____ Left eye date/doctor _____

Other prior eye conditions or concerns: ☐ None

_____

Eye Drops or Ointments that you use now: List drug name, which eye, and how ofter: ☐ None

_____

_____

Primary Physician: (local preferred) _____ Physician's city/state _____

Current medication list (including dosage): ☐ None ☐ List Attached

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: Please list any prior drug/substance allergy: ☐ No known drug allergies ☐ List Attached

	Drug/substance name:	Type of reaction:	Severity: (circle)
allergy to:	_____	_____	mild / moderate / severe
allergy to:	_____	_____	mild / moderate / severe
allergy to:	_____	_____	mild / moderate / severe
allergy to:	_____	_____	mild / moderate / severe
allergy to:	_____	_____	mild / moderate / severe

Please list other prior surgeries and the year (approximate if needed): ☐ None ☐ List Attached

_____

_____

Have you been diagnosed with any of the following?:

☐ High Blood Pressure ☐ Heart Disease ☐ Arthritis ☐ Asthma/COPD ☐ Cancer/type? _____

☐ High Cholesterol ☐ Stroke ☐ Thyroid - High or Low (please circle one) ☐ Diabetes/type? _____

Other medical history not listed above: ☐ None

_____

_____

Smoking: ☐ every day smoker ☐ social smoker ☐ former smoker ☐ never smoked

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

Drug Use: ☐ Yes ☐ No If yes, how much and how often? _____