

NEW VISION EYE CENTER PATIENT INFORMATION SHEET

DEMOGRAPHICS

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different from mailing): _____

Primary Phone: _____ Cell Phone: _____

Patient Employer: _____ Employer Phone: _____

Email Address: _____

Marital Status: _____ Sex: M F Date of Birth: ____/____/____

Social Security Number: _____

Emergency Contact Name: _____ RELATIONSHIP: _____

Emergency Contact Number: _____

How would you like us to contact you? Phone Text Email

The information below is required for Electronic Medical Records:

Pharmacy Name & Location: _____

Preferred Language: _____

Ethnicity: Non Hispanic or Latino Hispanic or Latino

Race: Asian Black | African American White Other

American Indian or Alaska Native Native Hawaiian or Pacific Islander

Which Doctor are you here to see?:

Minotty O'Brien Tate Reinauer Sayed

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Cardholder Name and DOB: _____

(If Minor) Parents Name and DOB: _____

Parents Phone: _____

How did you hear about us? Please include names.

Our Website Internet Search Radio TV Other _____

Newspaper/ Magazine: Vero Beach Magazine Indian River Magazine

Vero Beach 32963 Press Journal Vero/Seb. News

Screening Insurance Company Referred by: _____

(Doctor, Optometrist, Friend/Family)

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER: _____

DATE REGISTERED: _____

REGISTERED BY: _____



1055 37th Place | Vero Beach, FL 32960

T: 772.257.8700 | F: 772.257.8705

NewVisionEyeCenter.com | f @ t

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 Policy 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, 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 your 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 to, either by phone or documentation:

NAME: _____	RELATIONSHIP TO PATIENT: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____

Patient's Signature Date



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PAYMENT POLICIES

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:
ALL COPAYS/DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

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 that 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 your card.** It is also your responsibility to let us know if there is a change in your insurance information, including a new card. Failure to provide a copy of your card/updated information may result in increased out-of-pocket expenses, for which New Vision Eye Center is not liable.

If you are, or the patient you legally represent is, currently enrolled in a skilled nursing facility (SNF), hospice care, or a rehabilitation facility - it is your responsibility to inform us of this prior to your visit. Prior authorization is required from such facilities which may affect your appointment or our ability to provide you care.

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 not being seen for an emergency, and are unable to pay for prior balances from previous dates of service, you may be asked to reschedule your appointment.

Please note – Fees may be charged in the event of returned checks and/or unpaid balances that would result in your account being placed into collections/ pre-collections status. The amounts of these fees are listed below, and represent New Vision Eye Center’s associated costs.

- Checks returned for non-sufficient funds (NSF): **\$25.00 Fee**
- Placement of account into pre-collections status: **\$12.36 Fee**
- Placement of account into collections status: **\$12.36 Fee**

***Self-Pay patients are expected to pay in full at the time of service.**
We do not participate in auto injury claims or Worker’s Compensation claims.

Patient’s Signature

Print Name

Date

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

NEW VISION EYE CENTER MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Primary Physician (Local Preferred): _____

Primary reason(s) for today's visit: _____ City _____ State _____

- Cataract Glaucoma Dry Eye Diabetes Macular Degeneration Blurred Vision
 Other: _____

Past Medical History (please check all that apply):

- | | | |
|---|--|---|
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Leukemia |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Lung Cancer |
| <input type="radio"/> Asthma | <input type="radio"/> GERD | <input type="radio"/> Lymphoma |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Hearing Loss | <input type="radio"/> Pacemaker |
| <input type="radio"/> BPH | <input type="radio"/> Hepatitis | <input type="radio"/> Prostate Cancer |
| <input type="radio"/> Bone Marrow Transplantation | <input type="radio"/> Hypertension | <input type="radio"/> Radiation Treatment |
| <input type="radio"/> Breast Cancer | <input type="radio"/> HIV/AIDS | <input type="radio"/> Seizures |
| <input type="radio"/> Colon Cancer | <input type="radio"/> Hypercholesterolemia | <input type="radio"/> Stroke |
| <input type="radio"/> COPD | <input type="radio"/> Hyperthyroidism | <input type="radio"/> Valve Replacement |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypothyroidism | <input type="radio"/> None |
| <input type="radio"/> Other: _____ | | |

Past Surgical History (please check all that apply):

- | | | |
|---|---|---|
| <input type="radio"/> Appendix Removed | <input type="radio"/> PTCA | <input type="radio"/> Prostate Biopsy |
| <input type="radio"/> Bladder Removed | <input type="radio"/> Mechanical Valve Replacement | <input type="radio"/> Skin Biopsy |
| <input type="radio"/> Mastectomy (R,L,Bilateral) | <input type="radio"/> Biological Valve Replacement | <input type="radio"/> Basal Cell Cancer Surgery |
| <input type="radio"/> Lumpectomy (R,L,Bilateral) | <input type="radio"/> Heart Transplant | <input type="radio"/> Squamous Cell Carcinoma Surgery |
| <input type="radio"/> Breast Biopsy (R,L,Bilateral) | <input type="radio"/> Kidney Biopsy (R,L) | <input type="radio"/> Melanoma Surgery |
| <input type="radio"/> Breast Reduction | <input type="radio"/> Kidney Removed (R,L) | <input type="radio"/> Hysterectomy: Fibroids |
| <input type="radio"/> Breast Implants | <input type="radio"/> Kidney Stone Removal (R,L) | <input type="radio"/> Heart Stint |
| <input type="radio"/> Colectomy: Colon Cancer Resection | <input type="radio"/> Kidney Transplant | <input type="radio"/> Joint Replacement, Knee (R,L Bilateral) |
| <input type="radio"/> Colectomy: Diverticulitis | <input type="radio"/> Ovaries Removed: Endometriosis | <input type="radio"/> Joint Replacement, Hip (R,L Bilateral) |
| <input type="radio"/> Colectomy: IBD | <input type="radio"/> Ovaries Removed: Cyst | <input type="radio"/> Joint Replacement within the last 2 years |
| <input type="radio"/> Gallbladder Removed | <input type="radio"/> Ovaries Removed: Ovarian Cancer | <input type="radio"/> None |
| <input type="radio"/> Coronary Artery Bypass | <input type="radio"/> Prostate Removed: Prostate Cancer | |
| <input type="radio"/> Other: _____ | | |

Past Ocular History (please check all that apply):

- | | |
|--|---|
| <input type="radio"/> Allergic Conjunctivitis | <input type="radio"/> Monovision |
| <input type="radio"/> Blepharitis | <input type="radio"/> Narrow Angles (R, L) |
| <input type="radio"/> Cataract (R, L) | <input type="radio"/> Ocular Hypertension |
| <input type="radio"/> Corneal dystrophy (R, L) | <input type="radio"/> Ophthalmic Migraine |
| <input type="radio"/> Diabetic retinopathy, background (R,L) | <input type="radio"/> Retinal Tear (R, L) |
| <input type="radio"/> Dry Eyes | <input type="radio"/> Retinal Detachment (R, L) |
| <input type="radio"/> Drusen (R, L) | <input type="radio"/> Soft/Hard Contact Lens Wearer |
| <input type="radio"/> Glaucoma (R, L) | <input type="radio"/> Strabismus |
| <input type="radio"/> Macular Degeneration (R, L) | <input type="radio"/> Lazy Eye/ Amblyopia |
| <input type="radio"/> Macular Pucker (wrinkle) (R, L) | <input type="radio"/> Floaters (R, L) |
| <input type="radio"/> Other: _____ | |

Past Ocular Surgery (please check all that apply):

- | | | |
|--|--|--|
| <input type="radio"/> Blepharoplasty (R, L) | <input type="radio"/> LASIK (R, L) | <input type="radio"/> Strabismus Surgery |
| <input type="radio"/> Cataract Surgery (R, L) | <input type="radio"/> Monovision (R,L) | <input type="radio"/> Retinal Laser (R, L) |
| <input type="radio"/> Corneal Transplant (R, L) | <input type="radio"/> PRK (R, L) | <input type="radio"/> Trabeculectomy |
| <input type="radio"/> DSAEK (R,L) | <input type="radio"/> Ptosis Repair | <input type="radio"/> Tube Shunt (R, L) |
| <input type="radio"/> Eye Muscle Surgery | <input type="radio"/> Punctal Repair | <input type="radio"/> Yag Capsulotomy (R, L) |
| <input type="radio"/> Intravitreal Injections (R, L) | <input type="radio"/> Punctal Plugs (R, L) | <input type="radio"/> None |
| <input type="radio"/> Other: _____ | | |

Family History - Immediate Family Member Only (please check all that apply):

- | | | |
|------------------------------------|--|--|
| <input type="radio"/> Blindness | <input type="radio"/> Glaucoma | <input type="radio"/> Migraine |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Disease | <input type="radio"/> Retinal Detachment |
| <input type="radio"/> Cataracts | <input type="radio"/> High Blood Pressure | <input type="radio"/> Strabismus |
| <input type="radio"/> CVA/ Stroke | <input type="radio"/> High Cholesterol | <input type="radio"/> None |
| <input type="radio"/> Diabetes | <input type="radio"/> Macular Degeneration | |
| <input type="radio"/> Other: _____ | | |

Current Medication List: None List Attached

_____	_____
_____	_____
_____	_____

Allergies (Please list any prior drug/substance allergy): None List Attached

DRUG/SUBSTANCE NAME	TYPE OF REACTION	
_____	_____	Mild/ Moderate/ Severe
_____	_____	Mild/ Moderate/ Severe
_____	_____	Mild/ Moderate/ Severe

Eye Drops (Please list any prior drug/substance allergy): None List Attached

_____	_____
_____	_____
_____	_____

Are you currently experiencing any of the following? (please check all that apply):

- | | | |
|---|---|---|
| <input type="radio"/> Poor Vision | <input type="radio"/> Thyroid Abnormalities | <input type="radio"/> Joint Pain |
| <input type="radio"/> Eye Pain | <input type="radio"/> Chills | <input type="radio"/> Arthritis |
| <input type="radio"/> Tearing | <input type="radio"/> Ear Ache | <input type="radio"/> Headache |
| <input type="radio"/> Redness | <input type="radio"/> Dry Mouth | <input type="radio"/> Depression |
| <input type="radio"/> Loss of Vision | <input type="radio"/> Shortness of Breath | <input type="radio"/> Weakness |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Upset Stomach | <input type="radio"/> Head Injury |
| <input type="radio"/> Rapid Heart Rate | <input type="radio"/> Constipation | <input type="radio"/> Decreased Hearing |
| <input type="radio"/> Diabetes | <input type="radio"/> Incontinence | <input type="radio"/> None |
| <input type="radio"/> Other Symptoms: _____ | | |

**ALERTS: Have you ever or are you currently experiencing any of the following?
(Please check all that apply):**

- | | | |
|--|-------------------------------------|--|
| <input type="radio"/> Allergy to Lidocaine | <input type="radio"/> Defibrillator | <input type="radio"/> Pacemaker |
| <input type="radio"/> Allergy to Adhesive | <input type="radio"/> Flomax | <input type="radio"/> Rapid Heartbeat with Epinephrine |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> MRSA | <input type="radio"/> Steroid Responder |
| <input type="radio"/> Blood Thinners | <input type="radio"/> Narrow Angles | |
| <input type="radio"/> Other Symptoms: _____ | | |

Social History (please check all that apply):

CIGARETTE SMOKING

- | | | | |
|------------------------------------|---|--|------------------------------------|
| <input type="radio"/> Never Smoked | <input type="radio"/> Quit: Former Smoker | <input type="radio"/> Smokes Less Than Daily | <input type="radio"/> Smokes Daily |
|------------------------------------|---|--|------------------------------------|

ALCOHOL USE

- | | | | |
|----------------------------|---|--|--|
| <input type="radio"/> None | <input type="radio"/> Less than 1 Drink a Day | <input type="radio"/> 1-2 Drinks a Day | <input type="radio"/> 3 or More Drinks a Day |
|----------------------------|---|--|--|

DRUG USE

- None

Type of Drug

Frequency of Use



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