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 ◯ Khodadadeh

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: _____

NEW VISION EYE CENTER

1055 37th Place | Vero Beach, FL 32960
T: 772.257.8700 | F: 772.257.8705
NewVisionEyeCenter.com |

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): _____

City State

Primary reason(s) for today's visit:

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

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

Past Ocular History (please check all that apply):

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

Past Ocular Surgery (please check all that apply):

- ◯ Blepharoplasty (R, L)
- ◯ Cataract Surgery (R, L)
- ◯ Corneal Transplant (R, L)
- ◯ DSAEK (R,L)
- ◯ Eye Muscle Surgery
- ◯ Intravitreal Injections (R, L)
- ◯ LASIK (R, L)
- ◯ Monovision (R,L)
- ◯ PRK (R, L)
- ◯ Ptosis Repair
- ◯ Punctal Repair
- ◯ Punctal Plugs (R, L)
- ◯ Strabismus Surgery
- ◯ Retinal Laser (R, L)
- ◯ Trabeculectomy
- ◯ Tube Shunt (R, L)
- ◯ Yag Capsulotomy (R, L)
- ◯ None
- ◯ Other: _____

Eye Drops:

◯ None ◯ List Attached

_____ _____

_____ _____

_____ _____

Past Medical History (please check all that apply):

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

Past Surgical History (please check all that apply):

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

Current Medication List: ○ None ○ List Attached

_____ _____

_____ _____

_____ _____

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

- ○ Blindness
- ○ Cancer
- ○ Cataracts
- ○ CVA/ Stroke
- ○ Diabetes
- ○ Glaucoma
- ○ Heart Disease
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Macular Degeneration
- ○ Migraine
- ○ Retinal Detachment
- ○ Strabismus
- ○ None
- ○ Other: _____

Social History (please check all that apply):

CIGARETTE SMOKING

○ Never Smoked ○ Quit: Former Smoker ○ Smokes Less Than Daily ○ Smokes Daily

ALCOHOL USE

○ None ○ Less than 1 Drink a Day ○ 1-2 Drinks a Day ○ 3 or More Drinks a Day