NEW VISION EYE CENTER PATIENT INFORMATION SHEET

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?:
○ O'Brien ○ Tate ○ Reinauer ○ Piette

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 select all that apply.

○ Our Website
○ Internet Search
○ Social Media
○ Digital Advertising
○ Screening

○ Radio
○ TV
○ Direct Mail
○ Email

○ Referred by: ____________
(Doctor, Family or Friend Name)

Advertising or Article:
○ Vero Beach Magazine
○ Indian River Magazine
○ Spacecoast Magazine
○ Heartbeat of the Treasure Coast
○ Vero Beach 32963
○ Vero/Sebastian News
○ Press Journal
○ ____________

○ Other: ____________

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 |

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 James Hughes 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

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
	Mild / Moderate / Severe
	Mild / Moderate / Severe

Past Ocular Surgery (please check all that apply):

Please identify which eye surgery you have had, if any: (Please check all that apply and give the date and doctor)

○ Cataract surgery (Left Eye): Date__________ Doctor __________

○ Cataract surgery (Right Eye): Date__________ Doctor __________

○ Glaucoma surgery (Left Eye) Date__________ Doctor __________

○ Glaucoma surgery (Right Eye) Date__________ Doctor __________

○ Retinal surgery (Left Eye) Date__________ Doctor __________

○ Retinal surgery (Right Eye) Date__________ Doctor __________

○ Vision correction surgery (Left Eye) Date__________ Doctor __________

○ Vision correction surgery (Right Eye) Date__________ Doctor __________

○ Other (Left Eye) Date__________ Doctor __________

○ Other (Right Eye) Date__________ Doctor __________

○ **Other prior eye conditions or concerns:** ____

Eye Drops:

○ None ○ List Attached

Left Eye: ______________________ Right Eye: ______________________

Past Medical History (please check all that apply):

- ○ Alzheimer
- ○ Anxiety
- ○ Asthma
- ○ Atrial Fibrillation
- ○ BPH
- ○ Bone Marrow Transplantation
- ○ Cancer: ____________________
- ○ COPD
- ○ Coronary Artery Disease
- ○ Dementia
- ○ Depression
- ○ Diabetes (Type I)
- ○ Diabetes (Type II)
- ○ Hearing Loss
- ○ Hepatitis
- ○ Hypertension
- ○ HIV/AIDS
- ○ Hypercholesterolemia
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Pacemaker
- ○ Seizures
- ○ Stroke
- ○ Other: ____________________

Past Surgical History:

Please specify type of surgeries and dates:

Current Medication List (including dosage):

○ None ○ List Attached

Family History (other than yourself):

○ Unknown Family History

Please circle applicable family members:

○ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
○ High Blood Pressure	Parent / Sibling / Maternal Grandparent / Paternal Grandparent

Social History (please check all that apply):

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? ____________________

Other (please check all that apply):

Have you had a flu vaccine? ○ Yes ○ No

Have you had a pneumonia vaccine? ○ Yes ○ No

Have you had a COVID-19 vaccine? ○ Yes ○ No

Have you fallen in the last 2 years? ○ Yes ○ No

Are you currently in a wheelchair? ○ Yes ○ No

If yes, can you transfer without assistance? ○ Yes ○ No

Name: ____________________ Date of Birth: ____________ Today's Date: ____________