

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 to Contact: _____

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.

- | | | | |
|---|-----------------------------------|---|---|
| <input type="radio"/> Our Website | <input type="radio"/> Radio | Advertising or Article: | |
| <input type="radio"/> Internet Search | <input type="radio"/> TV | <input type="radio"/> Vero Beach 32963 | <input type="radio"/> Press Journal |
| <input type="radio"/> Social Media | <input type="radio"/> Direct Mail | <input type="radio"/> Vero/Sebastian News | <input type="radio"/> Heartbeat of the Treasure Coast |
| <input type="radio"/> Digital Advertising | <input type="radio"/> Email | <input type="radio"/> Vero Beach Magazine | <input type="radio"/> Guide to Medical Services |
| <input type="radio"/> Screening | | <input type="radio"/> Indian River Magazine | <input type="radio"/> Senior Services Guide |
| | | <input type="radio"/> Spacecoast Magazine | <input type="radio"/> _____ |

Referred by: _____ Other: _____
(Doctor, Family or Friend Name)

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 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):

- | | | |
|---|---|--|
| <input type="radio"/> Alzheimer | <input type="radio"/> Coronary Artery Disease | <input type="radio"/> HIV/AIDS |
| <input type="radio"/> Anxiety | <input type="radio"/> Dementia | <input type="radio"/> Hypercholesterolemia |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Hyperthyroidism |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Diabetes (Type I) | <input type="radio"/> Hypothyroidism |
| <input type="radio"/> BPH | <input type="radio"/> Diabetes (Type II) | <input type="radio"/> Pacemaker |
| <input type="radio"/> Bone Marrow Transplantation | <input type="radio"/> Hearing Loss | <input type="radio"/> Seizures |
| <input type="radio"/> Cancer: _____ | <input type="radio"/> Hepatitis | <input type="radio"/> Stroke |
| <input type="radio"/> COPD | <input type="radio"/> Hypertension | |
| <input type="radio"/> 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:

- | | |
|--|--|
| <input type="radio"/> Glaucoma | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> Macular Degeneration | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> Blindness | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> Diabetes | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> Cancer | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> Heart Disease | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="radio"/> 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: _____