SOUTH FLORIDA VISION CENTERS

Welcome to our Office

DATE: _____

Please help us get to know you by completing the following . . . . and remember to write clearly and legibly. Thank you.

NAME: _____ AGE: _____ DATE OF BIRTH: ____/____/____
LAST FIRST M.I. MONTH DAY YEAR

ADDRESS: _____
STREET NUMBER AND NAME

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ _____ OCCUPATION: _____
RESIDENCE WORK

SOCIAL SECURITY NUMBER: _____ PARENT/GUARDIAN NAME: _____
IF PATIENT IS A MINOR CHILD

INSURANCE COMPANY: _____ IDENTIFICATION: _____

INDIVIDUAL RESPONSIBLE FOR ACCOUNT: _____

VISION HISTORY

REASON FOR YOUR VISIT TODAY: _____

_____

APPROXIMATE DATE OF LAST EYE EXAMINATION: _____ DOCTOR'S NAME: _____

DO YOU WEAR EYEGLASSES? ☐YES ☐NO CONTACT LENSES? ☐YES ☐NO

HAVE YOU HAD AN EYE INJURY THAT AFFECTED YOUR VISION? ☐YES ☐NO IF YES, DESCRIBE INJURY _____

_____

HAVE YOU HAD EYE SURGERY? ☐YES ☐NO IF YES, WHICH EYE(S)? ☐RIGHT ☐LEFT ☐BOTH IF YES, DESCRIBE SURGERY

_____

CHECK ALL OF THE FOLLOWING THAT YOU EXPERIENCE OR THAT APPLIES TO YOU:

☐BLURRED VISION AT DISTANCE, WITH EYEGLASSES ☐BLURRED VISION AT CLOSE RANGE, WITH EYEGLASSES
☐ITCHING ☐BURNING ☐TEARING ☐ACHING ☐THROBBING ☐DISCHARGE
☐DOUBLE VISION ☐EYE PAIN ☐HEADACHES ☐OTHER _____

GENERAL HEALTH & MEDICAL HISTORY

FAMILY PHYSICIAN: _____ TELEPHONE: _____

ADDRESS: _____

OPHTHALMOLOGIST: _____ TELEPHONE: _____

ADDRESS: _____

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS? ☐YES ☐NO IF YES, WHAT CONDITIONS? ___

_____

WHAT WAS THE DATE OF YOUR LAST GENERAL HEALTH EXAM? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING ANY HORMONES OR BIRTH CONTROL PILLS): _____

_____

DO YOU HAVE ANY ALLERGIES INCLUDING DRUG ALLERGIES? ☐YES ☐NO IF YES, PLEASE LIST: _____

_____

CONTINUED ON BACK – PLEASE COMPLETE FORM IN ITS ENTIRETY

CHECK ALL THAT APPLY:	YOURSELF	FATHER	MOTHER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER
DIABETES	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐	☐
CATARACT	☐	☐	☐	☐	☐	☐	☐
MACULAR DEGENERATION	☐	☐	☐	☐	☐	☐	☐

INSURANCE SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made either to me or on my behalf to South Florida Vision providers for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration (CMS) and its agents any information needed to determine these benefits payable for related services.

_____ _____

Lifetime Patient Signature Date

NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at 954-977-5262, ext 25.

I am in receipt of the Notice of Privacy Practices for South Florida Vision

_____ _____

Signature Date