NEW PATIENT INFORMATION SHEET

Patient Name: ______________________________

Local Address: ______________________________ ______________________
City / State / Zip

Alternate Address: ______________________________ ______________________
City / State / Zip

What months are you at your alternate address? From ______________ To ______________

Local Phone: ______________________ Alternate Phone: ______________________

Cellular Phone: ______________________ Email Address: ______________________

Patient Employer: ______________________ Employer Phone: ______________________

Patient Date of Birth: ______________________ Sex: M ________ F ________

Patient SS#: ______________________ Emergency Contact: ______________________

Marital Status: ______________________ Emergency Contact Phone: ______________________

Spouses Name: ______________________ Spouse's DOB: ______________________

(If Minor) Parent Name: ______________________ DOB: __________ Daytime Phone: __________

Driver's License Number: ______________________________ State: ______________

INSURANCE INFORMATION

Primary Insurance: ______________________ Secondary Insurance: ______________________

ID#: ______________________ ID #: ______________________

Please give cards to receptionist to make copies. Thank you.

WHICH DOCTOR ARE YOU HERE TO SEE: (please circle one)

Val Zudans, M.D. Karen D. Todd, M.D. Thomas A. Baudo, M.D.

Wilson K. Wallace, M.D. Robert K. Butler, M.D. Other ______________

How did you hear about us? Please include names.

______ Patient ______________________ ______ Insurance Company

______ Family Member ______________________ ______ Seminar

______ Referred by M.D. ______________________ ______ Our Website

______ Optometrist ______________________ ______ Senior Services Guide

______ Newspaper - Name ______________________ ______ Yellow Pages

______ Radio - Station Name ______________________ ______ Other - Please Specify __________

Would you like to be notified about upcoming seminars, new information, products and services? ☐ Yes ☐ No

Please indicate the reason for your visit.

______ Routine eye Exam ______ Diabetic Exam ______ Interest in Laser Vision Correction

______ Cataract Check ______ Glaucoma Check ______ Need New Glasses

______ Having a Problem - Medical ______ Contact Lenses

______ Other ______________________________

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Account Number: ______________________

Date Registered: ______________________ Registered By: ______________________

FLORIDA EYE INSTITUTE

J. VAL ZUDANS, M.D.
Board Certified Ophthalmologist
Cataract Surgery, Refractive Surgery
General Ophthalmology

KAREN D. TODD, M.D.
Board Certified Ophthalmologist
Glaucoma, General Ophthalmology
Cataract Surgery

2750 INDIAN RIVER BLVD.
VERO BEACH, FL 32960
(772) 569-9500
1-800-423-7703
FAX (772) 569-9507

THOMAS A. BAUDO, M.D.
Board Certified Ophthalmologist
Retinal Specialist
Macular Degeneration, Diabetic Eye Disease
Medical and Surgical Retina

Florida Eye Institute

FINANCIAL POLICY

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please ask us if you have any questions.

INSURANCE

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our office does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contact information is located on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier.
Some insurance plans require an authorization for services in our office. It is your responsibility to acquire the appropriate paperwork. If the visit is not authorized, you will be responsible for the cost of services.
We will send your insurance carrier(s) a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

PAYMENT EXPECTATIONS

If you are not covered by insurance, you will be required to pay for your services on the date the service is received. All patients are required to pay co-payments, deductibles and co-insurance at the time of your visit. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty days of receipt of the statement. Our office accepts cash, checks and VISA/MasterCard/Discover.

There will be a $25.00 charge for any returned check.
There will be a $35.00 charge for any account having to be placed with a collection agency.

I have read and understand this policy.

Signature ________________________________ Date ______________________

12/2009

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Medical and Surgical Retina

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 Policies* 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 officer in writing at:

Florida Eye Institute
Attention: Information Privacy Officer
2750 Indian River Boulevard
Vero Beach, Florida 32960

If you *do not* sign this *Consent Form*, we have the right to refuse you 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 the 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 reaction, or you may simply send us a letter in writing.

By signing this consent, you acknowledge that you have been given the opportunity to read the "*Notice of Privacy Policies.*"

____
Patient's Signature

Date ____________________

____
Print Name

Florida Eye Institute
Medical History Questionnaire

Name: ______________________________ Date: ____________________

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: ☐ Cataract ☐ Glaucoma ☐ Dry Eye ☐ Blurred Vision ☐ Diabetes ☐ Macular Degeneration ☐ Other ______________________________

Do you presently have any problems in the following areas? If "YES", please give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	________
Loss of side vision, double vision	[ ]	[ ]	________
Itching, burning, or discharge	[ ]	[ ]	________
Redness	[ ]	[ ]	________
Gritty feeling, dryness or tearing	[ ]	[ ]	________
Glare/light sensitivity, or halos	[ ]	[ ]	________
Eye pain or soreness	[ ]	[ ]	________
Infection of eye lashes or lid, styes	[ ]	[ ]	________
Ears, Nose, Mouth, Throat	[ ]	[ ]	________
Cardiovascular (heart, blood vessels)	[ ]	[ ]	________
Respiratory (lungs/breathing)	[ ]	[ ]	________
Gastrointestinal (stomach/intestines)	[ ]	[ ]	________
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	________
Musculoskeletal (muscles/joints)	[ ]	[ ]	________
Integument (skin/breast)	[ ]	[ ]	________
Neurological	[ ]	[ ]	________
Psychiatric	[ ]	[ ]	________
Endocrine (hormones, glands)	[ ]	[ ]	________
Hematologic/Immunologic (blood)	[ ]	[ ]	________
Seasonal Allergies (hay fever, etc.)	[ ]	[ ]	________

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	

____

____

	YES	NO	
Allergies to eye drops	[ ]	[ ]	

List drops you are allergic to on line below:

____

	YES	NO	
History of cataract, glaucoma	[ ]	[ ]	________
History of cross/lazy eye	[ ]	[ ]	________
Eye Injury or other disease	[ ]	[ ]	________
Eye Surgery	[ ]	[ ]	________

Medical History Questionnaire

PAST HISTORY (MEDICAL)

List any medications (other than eye drop) that you are currently taking:

___

List all major illnesses: ☐ Diabetes ☐ Hypertension ☐ Other ____

List any major surgical procedures:

___

Do you have any medication allergies? [ ]NO [ ] YES Penicillin Sulfa

List other medication allergies:

___

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	____
Cataract	[ ]	[ ]	____
Glaucoma	[ ]	[ ]	____
Macular Degeneration	[ ]	[ ]	____
Retinal Detachment	[ ]	[ ]	____
MEDICAL			
Diabetes	[ ]	[ ]	____
Arthritis, Lupus, etc.	[ ]	[ ]	____
Other (list)	[ ]	[ ]	____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	____
Did you have problems with contacts?	[ ]	[ ]	____

Vision causes problems with:

☐Driving ☐Night Vision ☐Reading ☐Sports/Outdoor Activities

	YES	NO	EXPLANATION
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much per day?____
Do you smoke?	[ ]	[ ]	____
Have you ever had a blood transfusion?	[ ]	[ ]	____
Have you ever had contact with a person who had a sexually transmitted disease?	[ ]	[ ]	____

Patient's Signature: ____ Date: ____

History reviewed [ ] No Changes [ ] Additions as noted

Physician's Signature: ____ Date: ____

Refraction Fee: Refraction is the measurement of glasses prescription for the purpose of prescribing new glasses or determining the best-corrected visual potential of the eye. Medicare and many private medical insurance programs do not cover this service and require a separate charge apart from the medical part of the exam. Some supplemental insurance will reimburse this fee. You will need to contact your insurance company to find out if and how they cover this service. You will be given a receipt if this service is performed. **The refraction fee is $40.**

FLORIDA EYE INSTITUTE

MEDICAL HISTORY QUESTIONAIRE UPDATE

NAME: ______________________________ DATE: ____________________

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: ☐ Cataract ☐ Glaucoma ☐ Dry Eye ☐ Blurred Vision ☐ Diabetes ☐ Macular Degeneration ☐ Other ______________________________

Do you presently have any problems in the following areas? If "YES", please give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	____________
Loss of side vision, double vision	[ ]	[ ]	____________
Itching, burning, or discharge	[ ]	[ ]	____________
Redness	[ ]	[ ]	____________
Gritty feeling, dryness or tearing	[ ]	[ ]	____________
Glare/light sensitivity, or halos	[ ]	[ ]	____________
Eye pain or soreness	[ ]	[ ]	____________
Infection of eye lashes or lid, styes	[ ]	[ ]	____________
Ears, Nose, Mouth, Throat	[ ]	[ ]	____________
Cardiovascular (heart, blood vessels)	[ ]	[ ]	____________
Respiratory (lungs/breathing)	[ ]	[ ]	____________
Gastrointestinal (stomach/intestines)	[ ]	[ ]	____________
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	____________
Musculoskeletal (muscles/joints)	[ ]	[ ]	____________
Integument (skin/breast)	[ ]	[ ]	____________
Neurological	[ ]	[ ]	____________
Psychiatric	[ ]	[ ]	____________
Endocrine (hormones, glands)	[ ]	[ ]	____________
Hematologic/Immunologic (blood)	[ ]	[ ]	____________
Seasonal Allergies (hay fever, etc.)	[ ]	[ ]	____________

CHANGES IN HISTORY, MEDICATIONS, ALLERGY SINCE LAST VISIT

New Medical Diagnosis	[ ]	[ ]	____________
New Allergies	[ ]	[ ]	____________
New Medication(s) Medical	[ ]	[ ]	____________
New Medication(s) Eye	[ ]	[ ]	____________
Recent Eye Surgery	[ ]	[ ]	____________
New Eye Diagnosis	[ ]	[ ]	____________
New Family History	[ ]	[ ]	____________

Patient's Signature: ______________________________ Date: ______________

History reviewed [ ] **No Changes** [ ] **Additions as noted**

Physician's Signature: ______________________________ Date: ______________

Refraction Fee: Refraction is the measurement of glasses prescription for the purpose of prescribing new glasses or determining the best-corrected visual potential of the eye. Medicare and many private medical insurance programs do not cover this service and require a separate charge apart from the medical part of the exam. Some supplemental insurance will reimburse this fee. You will need to contact your insurance company to find out if and how they cover this service. You will be given a receipt if this service is performed. **The refraction fee is $40.**

AESTHETICS CENTER
NEW PATIENT INFORMATION

Patient Name: ______________________ What name do you prefer to be called? _______________
Local Address: _______________________________________ ________________________________
(City, State, Zip)
Alternate Address: ____________________________________ ________________________________
(City, State, Zip)
What Months are you at alternate address? From: _____________ To: _________________

Phone Numbers (We should have at least one way to reach you about appointments)
Local: ____________________ May we leave a message at this number? Y ___ N ___ Rank 1 2 3
Cellular: _________________ May we leave a message at this number? Y ___ N ___ Rank 1 2 3
Alternate: ________________ May we leave a message at this number? Y ___ N ___ Rank 1 2 3
Please note any special phone instructions (including hours): ____________________________________

Email (We hate spam and will never give your email address out to other businesses or individuals.)
Primary: ___________________________________ Alternate: ___________________________________
May we send you announcements and specials from The Aesthetics Center? Yes ___ No ___
(We expect to send out less than one such email per month on average.)
Please note any special email instructions: ____

Patient Date of Birth:_______________ Sex: M_____ F ______
Patient SS#: ______________________ Emergency Contact: _____________________________
Marital Status:_____________________ Emergency Contact Phone: ______________________
Spouse's Name: ____________________ Spouse's Date of Birth: ___________________________

How did you hear about us? Please include names.
____ Patient ____
____ Family / Friend _________________________________
____ Referred by M.D. ________________________________
____ Newspaper – Name _______________________________
____ Radio – Station Name_____________________________
____ Other (Please Specify) ___________________________
_____ Seminar
_____ Our website (www.fleye.com)
_____ Other website ____________
_____ Yellow Pages
_____ Spa / Gym ______________

Would you like to be notified about upcoming seminars, new information, products and services?
Yes ____ No ____ Do you prefer regular mail, email or both? _________________________

I'm interested in (please check all that apply):
____ Wrinkle reduction
____ Improved skin texture
____ Lip enhancement
____ Improve skin folds and creases
____ Hair removal
____ Botox
____ Skin care products
____ Other (please specify) _________________
____ Brown / Age spot removal
____ Longer, thicker lashes
____ Reduce redness
____ Skin tightening
____ Facial or leg vein treatment
____ Juvéderm, Radiesse or other fillers
____ Complimentary Aesthetics consultation

Is there anything else we should know about you?____

_____________________DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY _____________________

Account Number: ____________________
Date Registered: _____________________ Registered by: __________________