DV EYE CENTER

Medical History Interview

Name____ Today's Date____/____/______
Address____ Date of Birth____/____/______
City______________________State_____Zip________ Age_______
Phone ( )_________________________________ Social Security______-_____-_______
Name of Primary Care Medical Doctor__________________________ Occupation____________________
Last Medical Exam____________________________ Last Eye Exam_________________
E-mail address____

What is your reason for today's exam? Please mark all that apply.

[ ]Contact Lens	[ ]Blur at Distance	[ ]Double Vision
[ ]Glasses	[ ]Blur at Near	[ ]Glaucoma
[ ]Red Eye	[ ]Lazy Eye	[ ]Diabetes
[ ]Eye Pain/Discomfort	[ ]Itching	[ ]Lasik Exam
[ ]Flashes/Floaters	[ ]Discharge/Tears	[ ]Other____________________

Have you had an eye injury? No [ ] Yes [ ] If yes, explain:_______________________________________
Have you had eye surgery? No [ ] Yes [ ] If yes, explain:_______________________________________
Do you wear glasses? No [ ] Yes [ ] If yes, how old are your current glasses?__________________________
-Are you happy with your vision with your glasses? No [ ] Yes [ ]
Do you wear contact lenses? No [ ] Yes [ ] If yes, what brand?_______________________________________
-Are you happy with the comfort of the contact lenses? No [ ] Yes [ ]
-Are you happy with the vision of the contact lenses? No [ ] Yes[ ]
Are you interested in Lasik / Refractive Surgery? No [ ] Yes [ ]

Medical/Ocular History: (Please mark any condition that applies to yourself or and members of your immediate family)

	Self Family		Self		Self
Diabetes	[ ] [ ]	Breathing Problems	[ ]	Headache	[ ]
High Blood Pressure	[ ] [ ]	Kidney/Urinary	[ ]	STD	[ ]
Heart Disease	[ ] [ ]	Sinus/Allergy	[ ]	HIV/AIDS	[ ]
Arthritis/Joint Pain	[ ] [ ]	Thyroid/Glands	[ ]	Cancer	[ ]
Blindness	[ ] [ ]	Depression/Anxiety	[ ]	Other	[ ]
Retinal Disease	[ ] [ ]	Skin Condition	[ ]	Explain_________	
Glaucoma	[ ] [ ]	Hearing Loss	[ ]	_________________	
Macular Degeneration	[ ] [ ]	Stroke	[ ]	_________________	
Cataracts	[ ] [ ]	Neurological	[ ]		

Do you take any medications? No [ ] Yes [ ] If yes, list: ____
____
Do you have any allergies? No [ ] Yes [ ] If yes, explain: ____
Are you now pregnant? No [ ] Yes [ ] If yes, how long? ____
Do you smoke? No [ ] Yes [ ] How much?____
Do you drink alcohol? No [ ] Yes [ ] How much?____
Do you take any recreational drugs? No [ ] Yes [ ] Please list_______________________________________

DV EYE CENTER

Notice of Privacy Practices

-This notice describes how your health information may be used and disclosed. Please review it carefully.
-At DV Eye Center, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
-The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
-You may request in writing that we not use or disclose your health information as described above. As we will need to contact you from time to time, we will use address, telephone numbers or email address we have on file. You have the right to transfer copies of your health information to another practice. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records request form in regards to the information you are requesting.
-If we change the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at 407-207-5310. This notice goes into effect as of April 1, 2003.

Acknowledgement

I have received a copy of DV Eye Center Notice of Privacy Practices.

***Signed: ______________________________Print Name:____________________________Date:____/____/____

Dilation Release Authorization

The purpose of dilating your pupil is to perform a more thorough examination of the health of your retina by viewing behind the iris or colored area. This allows the doctor access to the peripheral retina, which would normally be blocked. Florida law requires all new patients to have this procedure done on their initial visit. Certain side effects may occur and are common such as blurry vision, nausea, dry mouth, light sensitivity, and burning on instillation of drops. Blurred vision typically lasts about 3-4 hours.

[ ] I have read the following statement and wish to be dilated.

[ ] I understand the importance of the procedure but wish not to be dilated and agree to hold DV Eye Center and their doctors harmless as a result of my action.

***Patient/ Guardian Signature____Date____/____/______

Insurance Information

Vision Care Insurance

Insurance Co:______________________Insured Name___________________Insured's Employer_________________
Member ID#_______________________Group #________________Plan#_______________________

Medical Insurance

Insurance Co:______________________Insured Name___________________Insured's Employer_________________
Member ID#_______________________Group #________________Plan#_______________________

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to me or on my behalf to DV Eye Center for services or supplies rendered.

Note: Most insurance policies pay only a portion of your total charges. You are responsible for all charges that are denied/not covered by your insurance. We **DO NOT** guarantee the accuracy of benefit information given to us by insurance companies. You must present your insurance card or any discounts plans on the day of service. **Please understand the financial responsibility is yours not your insurance company.**

***Patient/ Guardian Signature____Date____/____/______

DV EYE CENTER

Financial and Office Policy

• Thank you for choosing DV Eye Center as your Vision Care Provider. As a part of our services, we try to contain the ever-rising cost of vision care. In an effort to do that, we request you read and sign the following financial policy prior to treatment. Patient or responsible party must complete our form before seeing our doctors.

• FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, Visa, Mastercard and Discover. If you are purchasing eyeglasses or contacts, **you will be expected to pay in full before any orders can be processed.**

• Office Policy: Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within **60** days you (the patient) will be notified. Returns or cancellations are made at the discretion of the office manager and only in office credit will be issued. Progressive lenses have a non-adapt 90 days warranty, which means we can exchange the lenses for single vision or lined bifocal lenses. Ophthalmic lenses for glasses are custom made for you. Sorry, no refunds. Please make your selection carefully.

• Minor Patients (under the age of 18): The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in **advance** and we must have parents or guardians written permission prior to treatment of a minor.

• Missed and Late Appointments: We do not resort to overbooking to cover "No Shows". So it is urgently important that you cancel or reschedule **at least 24 hours in advance**. We reserve the right to bill a $30.00 charge for missed appointments. Should you arrive more than 15 minutes late for your scheduled appointment, we will have to reschedule you for a different date.

• Spectacle Prescription: If the patient desires to take their spectacle lens prescription elsewhere, DV Eye Center will not be responsible for any warranty on glasses made elsewhere. There will be a charge on any prescription rechecks done by our doctors at DV Eye Center after 60 days from the date of the exam. However, our optician will be happy to check the prescription of your glasses against your prescription given by our doctors at no charge.

• Contact Lens Patients: Additional time and testing is required for the fitting and evaluation for contact lenses so there will be an additional professional fee charged outside of the comprehensive examination fee. Patients have thirty days of follow-up care from the date of the fitting to make any necessary changes in the prescription, any visits after thirty days, a fee will be incurred. A contact lens prescription is only valid **one year from the exam date** and cannot be filled once expired. Once contacts have been ordered and received by the patient, contact lenses cannot be returned. If the patient desires to take their contact lens prescription elsewhere, DV Eye Center will not be responsible for any warranty on their contact lenses, and all follow-up visits will be charged an additional professional fee. Eyeglass and contact lens prescriptions (when requested) are faxed at the end of each business day.

***Patient/ Guardian Signature____Date____/____/______