NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE

Thank you for choosing North Florida Cataract Specialists and Vision Care for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Our physicians and staff are dedicated to providing you with the highest quality service and care. We will do our very best to make sure your visit is as pleasant and comfortable as possible.

In order to better serve you, we ask that you allow at least 2 hours total for your visit. You can also expect to have your pupils dilated at your appointment. We would like to remind you that any copays, unmet deductibles or coinsurance will be due at the time of your visit. Payment by cash, check, VISA, MasterCard, American Express or Discover is accepted.

We have enclosed our new patient packet for you to fill out and bring with you to your appointment. Please also be prepared to bring the following:

- Glasses and/or contact lens prescription (please bring contact lens box)
- A list of current medications you are using
- A list of medications you are allergic to
- Insurance cards
- Records from your previous doctor (or you can request to have them sent to our office)

We understand that situations may arise that will interfere with your scheduled appointment time and will be happy to assist you in rescheduling. When canceling or rescheduling your appointment, kindly give at least 24 hours notice. Failure to do so may result in a $50 charge.

If you have any questions or concerns, please do not hesitate to contact our office. We can be reached at 352-373-4300 or 1-800-435-3937. We look forward to providing you with the very best of care!

NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE

Main Office
4313 NW 8th Ave
Gainesville, FL 32605

Tioga Office
12921 SW 1 Rd, Ste 107
Tioga, FL 32669

Main Phone: 352-373-4300
Tioga Phone: 352-333-1186
Fax: 352-373-4572

www.northfloridavision.com

PLEASE PRINT CLEARLY

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____
Month Day Year

- If Patient is a minor: Father _____ DOB: _____/_____/_____
  Mother _____ DOB: _____/_____/_____
  Guardian _____ DOB: _____/_____/_____

Billing Address _____
City _____ State _____ Zip _____

Phone Numbers: Home ( ) _____-_____ Work ( ) _____-_____
Cell ( ) _____-_____

Email Address: _____
(This information will not be sold or shared with any third party.)

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married, Spouse's Name: _____ ☐ Other _____

Physician or person we may thank for this referral: _____

EMERGENCY CONTACT: Name _____ Phone _____

INSURANCE INFORMATION

Note: A copy of all insurance cards is necessary for our permanent records.

* Primary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

* Secondary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

INSURANCE SIGNATURE ON FILE/LIFETIME MEDICARE SIGNATURE

I request that payment of authorized benefits or other insurance be made on my behalf to North Florida Cataract Specialists and Vision Care for any services rendered. ***I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or non-covered services.*** I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or any other insurance carrier, any information needed to determine these benefits payable for related services.

My signature below attests to the fact that I have read and do understand the above-mentioned policies. A photocopy of this signature is as valid as an original.

PATIENT/GUARDIAN SIGNATURE _____
DATE _____

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the following person(s) to have access to my protected health information; example: spouse, son, daughter, parents, etc. I have listed his/her name(s) and relation to me.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

OPTIONAL I understand that I have the right to restrict the amount of information that the above individual(s) receive. The following are restrictions I would like to place:

_____

_____

- May we leave a message on your HOME answering machine if there is no answer?
  ☐ Yes ☐ No ☐ Do not have an answering machine

- **<u>If there any any changes to the above stated information, it is the patient or guardian's responsibility to inform North Florida Cataract Specialists and Vision Care in writing.</u>**

I hereby acknowledge that I have been presented with a copy of North Florida Cataract Specialists and Vision Care's Notice of Privacy Practices & authorize the above listed person(s) access to my protected health information.

Patient's Signature: _____

If minor, Guardian's Signature: _____

Patient's Name (Printed): _____

Witness: _____ Date: _____

REFRACTION POLICY

A refraction (procedure code 92015) is the part of the exam that evaluates any visual changes and the possible need for an eyeglass prescription. There is a $40 charge for this service. **This fee is not covered by most *medical insurance* plans and is due at the time of service.** Please be aware, although this charge is not covered, it may be necessary to perform a refraction to help determine visual changes related to medical conditions.

_____ _____

Patient's Signature Date

Patient Medications

Please include over-the-counter, vitamins/supplements and PRN (as needed) medications.

Medication Name	Strength	# Times Taken Daily	Route	Reason

Allergies	Reactions

Office Use Only:

Date Reviewed/Updated	Tech Signature

Name: _____ **DOB:** _____ **Acct:** _____

REVIEW OF SYSTEMS: (Please mark all that apply)

CONSTITUTIONAL SYMPTOMS:
Fever ____
Weight Loss/Gain ____
Weakness ____
SOB ____
Numbness ____
Swelling ____
Coughing ____
Aches / Pains ____

CARDIOVASCULAR:
Hypertension ____
Heart Attack ____
Stroke ____
Congestive Heart Failure ____
Coronary Artery Disease ____
Angina ____
Heart Murmur ____
Arrhythmia ____
Peripheral Vascular Disease ____

PULMONARY DISEASE:
Asthma ____
Emphysema ____
Tuberculosis ____
Bronchitis ____
COPD ____
Sleep Apnea ____

MUSCULOSKELETAL:
Osteo Arthritis ____
Rheumatoid Arthritis ____
Fibromyalgia ____
Polymyositis ____
Gout ____

GASTROINTESTINAL:
Crohns disease ____
Liver Problems ____
Irritable Bowel ____
Reflux ____
Hiatal hernia ____

OTOLARYNGOLOGIC:
Sinusitis ____
Ear Infection ____

GENITOURINARY:
Prostate ____
Kidney ____
Urinary Tract Infection ____
Bladder Problems ____
Flomax or its generic ____

HEMATOLOGIC/LYMPHATIC:
Anemia ____
Sickle Cell ____
Bleeding ____

ENDOCRINE:
Diabetic (ID) | (NID) ____
Type ___ Year ___
Hypoglycemia ____
Hypo Thyroid ____
Hyper Thyroid ____
Pituitary Tumor ____
Cholesterol ____

INTEGUMENTARY:
Rosacea ____
Dermatitis ____
Cancer ____

ALLERGIC/IMMUNOLOGIC:
Seasonal Allergies ____
Lupus ____
HIV ____
AIDS ____

PSYCHIATRIC:
Anxiety ____
Depression ____
Manic-Depressive ____

NEUROLOGIC:
Epilepsy ____
Parkinsons ____
Dementia ____
TIA's ____
MS ____
Bells Palsy ____
Myasthenia Gravis ____
Migraines ____
Meniere's ____
Brain Tumor ____

OPHTHALMIC:
Glaucoma ____
Amblyopia ____
Strabismus ____
Cataracts ____
ARMD ____
Trauma ____
Retinopathy ____
Iritis ____
Cornea ____
Retinal Disease ____

EYE SURGERY/LASERS:
_____
_____
_____
_____

FAMILY HISTORY:
Glaucoma Y N
Diabetes Y N
Cataracts Y N
ARMD Y N

GENERAL SURGERIES:
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY:
Do you smoke? Y N
If yes, #packs per day: _____
When did you start? _____

Have you ever smoked: Y N
When did you stop? _____

Cessation counseling done? Y N

Do you drink? Y N
Drinks per day: ____

Do you take recreational drugs: Y N
If yes, what and how long:
_____

Occupation: _____

Have you had any recent unexplained medical problems? Y N Comments: _____
_____
_____

Initial date of review: _____ Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____

Patient Name: _____ DOB: _____ Acct: _____