



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: _____ Phone#: _____

Name: _____ Relation to patient: _____ Phone#: _____

Name: _____ Relation to patient: _____ Phone#: _____

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 voicemail if there is no answer?
 Yes No

- **If there are 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.**

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 \$45 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

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: _____