TREASURE COAST EYE ASSOCIATES, P.A. WELCOME TO OUR OFFICE

PATIENT INFORMATION

Date_____

Name_____
Street_____
City/State_____Zip_____
Home Phone_____Office_____
Sex: M F
Age_____ Date of Birth_____
Email_____

Would you like to receive communications by:

☐ text ☐ e-mail ☐ phone

Marital Status: Single Married Widowed Divorced
Soc Sec #:_____
Employer:_____
Occupation:_____
What is the main purpose of this visit?
_____
_____
_____

INSURANCE INFORMATION

Vision Insurance_____
Subscriber Name_____
Subscriber Soc Sec#_____
Subscriber ID#_____
Subscriber Birthdate_____

Medical insurance WILL cover eye examinations in many cases! Please enter your information below so we can determine your coverage.

Medical Insurance_____
Subscribers Name_____
Subscriber Soc Sec#_____
Subscriber ID#_____
Subscriber Birthdate_____
Secondary Insurance_____

Do you participate in a flex spending account?
☐ Yes ☐ No

How will you settle your account today?
☐ Cash ☐ Check ☐ Credit/Debit Card ☐ Finance

PRIVACY PRACTICE ACKNOWLEDGEMENT

A copy of Treasure Coast Eye Associates' Notice of Privacy Practices is available for review in the waiting room. Please look over this document if you desire, and sign below that you have had an opportunity to review it. Copies are available if you would like a copy to take with you.

_____
Signature

_____
Date

NEW PATIENTS ONLY

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

☐ Another Doctor _____
☐ Insurance List _____
☐ Yellow Pages: Which one?_____
☐ Newspaper/Radio/TV _____
☐ Web Site _____
☐ Other _____

ASSIGNMENT AND RELEASE (Sign below to allow us to file your insurance)

Medicare and most medical insurances do NOT pay for routine vision examinations or refractions (to determine prescription for glasses). If refraction is necessary or requested during the exam, these insurances will disallow it, stating it is a non-covered service. Therefore, the patient will be responsible for the refraction charge. The refraction charge is **$35**. If by chance your insurance does pay, we will refund that money to you.

The practice of waiving deductible and coinsurance amounts is illegal. I understand I am responsible for these payments.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above companies and assign directly to Dr. Brice Roselli or Treasure Coast Eye Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance, not Treasure Coast Eye Associates, and I am responsible for all charges whether or not paid by my insurance. If my insurance has not reimbursed this office in full within 90 days, I will be billed the outstanding balance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of Beneficiary_____ Date_____

(PLEASE FILL OUT OTHER SIDE ALSO)

The information in this confidential case history form is critical to the evaluation of your vision and health.

EYE HISTORY

Last Eye Examination_____
By Whom? _____

Do you wear glasses? ☐ YES ☐ NO
☐ All the time ☐ Occasionally
☐ Reading Only ☐ Distance Only

Contact Lens Wearers Only:

What kind do you wear?_____
Cleaning solutions used: _____
How often do you replace your contacts? _____
How often do you sleep in your contacts _____

Are you satisfied with the vision and comfort of your current contact lenses? ☐ YES ☐ NO

Are you experiencing any of these symptoms since your last exam?

☐ Blurry Vision
☐ Red Eyes
☐ Burning
☐ Double Vision
☐ Discharge
☐ Flashes of Light
☐ Seeing spots
☐ Dry Eye
☐ Tearing
☐ Itching
☐ Light Sensitivity
☐ Night Vision Problems
☐ Temporary Loss of Vision
☐ Other_____

Have you ever been diagnosed or treated for any of the following?

☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Eye Injury
☐ Retinal Disease/Detachment
☐ Blindness
☐ Eye Turn/Strabismus
☐ Lazy Eye/Amblyopia
☐ Diabetic Eye Problems
☐ Dry Eye
☐ Farsighted ☐ Nearsighted
☐ Other _____
☐ Eye Surgery for:_____
_____
_____

MEDICAL HISTORY

Primary Care Physician_____
Last Physical Exam_____

Have you ever been diagnosed or treated for the following health problems?

☐ Allergies
☐ Arthritis
☐ Asthma/Emphysema/COPD
☐ Blood disorder
☐ Cancer, what kind?
_____
☐ High Cholesterol
☐ Diabetes: Type 1 or Type 2
☐ Ears/Nose/Throat/Sinus
☐ Heart condition
☐ High Blood Pressure
☐ Kidney Disease
☐ Lupus/other autoimmune disease
☐ Migraine headaches
☐ Muscle/Bone problems
☐ Pacemaker
☐ Rheumatoid arthritis
☐ Shingles
☐ Skin condition
☐ Stroke
☐ Other brain disease
☐ Psychological
☐ Thyroid
☐ Other not listed_____
_____
_____

CURRENT MEDICATIONS
(including eyedrops and over the counter)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____

FAMILY MEDICAL/EYE HISTORY

Does anyone in your family have any of the following conditions? Please list the affected family members.

☐ Glaucoma_____
☐ Cataracts_____
☐ Macular Degeneration_____
☐ Retinal Disease_____
☐ Blindness_____
☐ Lazy Eye/Eye Turn_____
☐ Diabetes_____
☐ Cancer_____
☐ Heart Disease_____
☐ Other_____
_____

LIFESTYLE QUESTIONS

Do you….(check box if your answer is yes)

☐ ..Work at a computer?
☐ ..Think you might benefit from thinner, lighter lenses?
☐ ..have an interest in "test driving" the latest contact lens designs?
☐ ..Have any interest in changing your eye color?
☐ ..Spend time outdoors? How much? _____hrs/week
☐ ..Have prescription sun wear?
☐ ..Wish you could go without your glasses at times?
☐ ..Want information on Laser Vision Correction?
☐ ..Have more than 1 pair of current prescription eyewear?
☐ ..Play any sports? What sports? _____
☐ ..Have trouble seeing at night?
☐ ..Get glare from headlights at night while driving?
☐ ..Smoke, how many packs per day?_____
☐ ..former smoker?
☐ ..Drink alcohol?
☐ ..Use recreational drugs?

If you wear bifocals, do the lines or head tilting bother you?
☐ YES ☐ NO

Is there anything you dislike about your current prescription eyeglasses? _____
_____
_____

DIGITAL RETINAL EXAM

Please check the appropriate box as to whether you would like to enhance your visit today with the **Digital Retinal Exam** for an additional **$25**. This is recommended annually.

☐ YES ☐ NO