MID FLORIDA Eye CENTER

CATARACT & RETINA
LASER INSTITUTE
EXCELLENCE IN EYE SURGERY

Name:
Account#:

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

Preferred Contact#: ❒ Home ❒ Work ❒ Cell Marital Status: ❒Sing ❒Mar ❒Div ❒Wid ❒Sep

SSN:_____ DOB:_____ Sex: ❒ M ❒ F

Preferred Language: ❒ English ❒ Spanish ❒ Other_____

Street Address/City/State/Zip:_____

Billing Address:_____

Email Address:_____ Employer/Occupation:_____

Full Time Resident? ❒ Y ❒ N If No, Other Address:_____

Primary Care Physician:_____ Address:_____

Who Can We Thank For Referring You To Our Practice:
❒ Eye Doctor:_____ ❒ Other Doctor:_____
❒ Family/Friend ❒ Insurance ❒ Employer ❒ Website ❒ TV ❒ Magazine ❒ Newspaper ❒ Internet ❒ Billboard
❒ Yellow Pages ❒ MFE Bus ❒ Seminar/Health Fair ❒ Other_____

GUARANTOR OR RESPONSIBLE PARTY: ❒ Self (Patient) ❒ Other (If Patient Is Minor)

If Other, Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

DOB:_____ Relationship To Patient:_____

EMERGENCY CONTACT (Other than telephone number listed above)

Name:_____ Relationship To Patient:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

PRIMARY MEDICAL INSURANCE

Company:_____ ID#:_____ Group#:_____

Policyholder Name:_____ DOB:_____ Relationship To Patient:_____

SECONDARY MEDICAL INSURANCE

Company:_____ ID#:_____ Group#:_____

Policyholder Name:_____ DOB:_____ Relationship To Patient:_____

VISION INSURANCE **Vision Care Plan (Please Note, at this time MFEC only accepts ***Vision Care Plan*** for routine vision care)**

ID#:_____ Group#:_____ Policyholder Name:_____

DOB:_____ Relationship To Patient:_____

X_____ _____ X_____ _____
Patient Signature Date Parent or Guardian Signature Date

PATIENT CONSENT AND AUTHORIZATION

NAME:_____ **DATE:**_____

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to MFEC to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy or Medicare, and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interest, and attorney's fees. I hereby request payment of authorized Medicare benefits and/or any other including supplemental and Medigap insurance benefits for me to be paid directly to MFEC for any services furnished to me by MFEC. I authorize MFEC and staff to release to my insurance carrier and its agents any information concerning health care advice, treatment or supplies provided me, needed to determine these benefits or the benefits payable for related services. I understand this is a lifetime authorization.

FINANCIAL POLICY

PARTICIPATING HEALTH CARE INSURANCE PLAN OBLIGATION - MFEC maintains a list of health care plans with which it has contracted to provide services to patients. We have agreed to bill those insurance carriers for all services rendered. Authorization from your insurance company does not always guarantee full payment. The undersigned and/or patient shall remain responsible for all charges, applicable copayments, and deductibles.

SUPPLEMENTAL & NON PARTICIPATING INSURANCE - All fees are due at time of service. A receipt is provided which details the payment for the visit. A copy of itemized services and payment is available upon request to submit to your insurance carrier for you to receive payment.

INSURANCE WAIVER REGARDING NON-COVERED SERVICES - Medicare, (under section 1862 (a) (1) of the Medicare law), and some health insurance plans will only pay for services that they determine to be "reasonable and necessary". If they determine that a particular service is not "reasonable and necessary" under their program standards, or that services are unauthorized, or not a covered benefit under your plan, Medicare and other insurance plans will deny payment for those services. Payment is sometimes denied for the following services:

- Refraction
- Post Op Kits
- Premium IOL's
- Prescription Drugs
- Cosmetic Surgery
- Hearing Aids
- Lab Tests
- Copies of Medical Records
- Diagnostic Testing
- Out of Network Referrals
- Pre Existing Conditions

MINOR PATIENTS – An adult accompanying a minor and/or the parent or guardian of the minor is responsible for full payment. We are not a party to any divorce decree or other legal judgments that outlay responsibility for medical payments.

USUAL AND CUSTOMARY RATES – Our practice is committed to providing the best treatment for our patients and our charges are usual and customary for our area.

X_____ _____ **X**_____ _____

Patient Signature Date Parent or Guardian Signature Date

HIPAA AUTHORIZATION AND COMMUNICATION USE AND DISCLOSURE

I have had the opportunity to review MFEC's Privacy Practices.

In order to protect our patients' privacy, MFEC Group will not discuss or release any information regarding our patients without their written authorization. Should you wish to authorize MFEC Group to discuss your account or medical information with someone other than yourself, please indicate the permission below.

I authorize MFEC Group to discuss my personal medical and account history with the following individuals:

1._____ _____

Name Relationship

2._____ _____

Name Relationship

X_____ _____ **X**_____ _____

Patient Signature Date Parent or Guardian Signature Date

PATIENT MEDICAL HISTORY **NAME:**_____ **DATE:**_____

Please check YES or NO if you have or ever had any of the following:

❒ Y ❒ N Cancer - Type_____
❒ Y ❒ N Taken Flomax / Hytrin / Cardura
❒ Y ❒ N High Blood Pressure
❒ Y ❒ N Stroke / CVA
❒ Y ❒ N Heart Disease / Murmur
❒ Y ❒ N Heart Attack
❒ Y ❒ N Congestive Heart Failure
❒ Y ❒ N Irregular Heartbeat / Palpitations
❒ Y ❒ N Asthma
❒ Y ❒ N COPD
❒ Y ❒ N Migraines
❒ Y ❒ N Arthritis
❒ Y ❒ N Sleep Apnea - Use a CPAP? ❒Y ❒N

❒ Y ❒ N High Cholesterol
❒ Y ❒ N Thyroid Disease
❒ Y ❒ N Diabetes – ❒Oral ❒Diet ❒Insulin
❒ Y ❒ N GERD
❒ Y ❒ N Kidney Disease
❒ Y ❒ N Kidney Stones
❒ Y ❒ N Liver Disease
❒ Y ❒ N Hepatitis – ❒A ❒B ❒C
❒ Y ❒ N Auto-Immune Disease – Type_____
❒ Y ❒ N Infectious Diseases_____
❒ Y ❒ N Dementia / Memory Loss
❒ Y ❒ N MRSA

Have you received a pneumonia vaccine? ❒ Y ❒ N
Have you ever smoked? ❒ Y ❒ N - Do you still smoke? ❒ Y ❒ N
Do you drink alcohol? ❒ Y ❒ N - ❒Daily ❒Occasionally ❒Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

❒ No Surgical Procedures
❒ Bypass
❒ Pacemaker
❒ Heart Stints
❒ Knee Replacement
❒ Hip Replacement
❒ Prostate
❒ Colostomy
❒ Mastectomy
❒ Thyroidectomy
❒ Appendectomy
❒ Gallbladder
❒ Back Surgery
❒ Cataract Surgery
❒ LASIK / RK
❒ Retinal Detachment
❒ Cornea Transplant
❒ Glaucoma Procedure
❒ Eyelid Procedure

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

❒ Cataracts
❒ Glaucoma
❒ Macular Degeneration
❒ Diabetic Retinopathy
❒ Corneal Disease
❒ Amblyopia / Lazy Eye
❒ Other_____
❒ Other_____
❒ Other_____

ALLERGIES

❒ Yes – Please list below ❒ No Known Allergies Latex Allergy? ❒ Yes ❒ No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of: (Mother, Father, Siblings, Grandparents)

Diabetes ❒ Y ❒ N Who:_____
Glaucoma ❒ Y ❒ N Who: _____
Macular Degeneration ❒ Y ❒ N Who: _____
Blindness ❒ Y ❒ N Who: _____
Adopted/Unknown ❒

X_____ _____ **X**_____ _____

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REVIEW OF SYSTEMS

NAME:_____ DATE:_____

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Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- ☐ Overall Healthy
- ☐ Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever and Chills
- ☐ Weakness

Integumentary (Skin)

- ☐ Skin Cancer
- ☐ Rash
- ☐ Bruising
- ☐ Suspicious growths
- ☐ Itching

Ears/Nose/Mouth/Throat

- ☐ Dry Mouth
- ☐ Sinus Pain / Infections
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Wears hearing aids

Respiratory

- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Oxygen use
- ☐ Shortness of Breath

Cardiovascular

- ☐ Chest Pain
- ☐ Hypertension
- ☐ Heart attack
- ☐ Heart Surgery
- ☐ Palpitations

Gastrointestinal

- ☐ Heartburn / Acid reflux
- ☐ Diverticulitis
- ☐ Nausea
- ☐ Hernia
- ☐ Ulcers

Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Muscle pain / joint pain

Neurological

- ☐ Memory Loss
- ☐ Headaches
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Tremors

Endocrine

- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Frequent Urination
- ☐ Excessive thirst

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Allergies / Immunological

- ☐ Allergic reaction to medications
- ☐ Allergic reaction to foods
- ☐ Seasonal / Environmental allergies
- ☐ Autoimmune disease

Other conditions or medical problems not listed?:

_____

_____

_____

X_____ _____ **X**_____ _____

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Name:_____ Date:_____ Acct#:_____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation:_____

Hobbies:_____

In order for our doctors to assist you in making the best possible decision about your vision and hearing needs, please take a moment to complete the front and back of the questionnaire.

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment	**Circle One**			
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty performing detailed work (sewing, threading a needle, baiting a hook)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

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Please circle the activities you would prefer to do with less dependence on glasses:

Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone

Card or table games Sewing Applying makeup Using a computer Seeing price tags

View dashboard of car Seeing price tags/shelves Shopping Bingo Driving

Playing sports, like golf Watching TV Watching live sports Going to movies Swimming

X_____ _____ X_____ _____

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Name:_____ Date:_____ Acct#:_____

See Younger….Hear Younger

It's all about your quality of life!

Studies have shown that hearing and vision loss are commonly connected as we age.

Please answer the questions below	**Circle One**		
Do you have difficulty hearing when someone speaks to you?	Yes	No	Sometimes
Do you have difficulty understanding conversations when in groups or noisy situations?	Yes	No	Sometimes
Do you feel that your decreased sense of hearing limits or hampers your personal or social life?	Yes	No	Sometimes
Do you have difficulty hearing the TV or radio?	Yes	No	Sometimes
Do you frequently have to ask others to repeat themselves?	Yes	No	Sometimes
Are you unable to understand when someone talks to you from another room?	Yes	No	Sometimes
Have others told you that you don't seem to hear them?	Yes	No	Sometimes

As a patient of Mid Florida Eye Center, a hearing evaluation is included with your complete eye exam for patients 60 years or older or for anyone who answers "Yes" to the above questions at no additional charge.