Ft. Lauderdale
Eye Associates

Retina Macula Specialists of Miami

George A. Fournier, MD
Aarup Kubal, MD
Anil Vedula, MD
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Heather Groves, OD

2466 E. Commercial Blvd
Ft. Lauderdale, FL 33308
Office: 954-492-1177 Fax: 954-492-0352 www.ftleye.com

Today's Date:_____

Patient Name_____ Date of Birth: _____/_____/_____ Age:_____

Primary Care Physician: _____Phone # of PCP_____

Previous Eye Doctor:_____Phone:_____

Date of your last Eye Exam:____/____/_____

- Please circle **Yes or No** to the below questions and include any relevant explanation.

Ocular Symptoms ☐ *None*		*Explanation*
Are you satisfied with your vision?	N Y	
Do you wear Glasses or Contacts	N Y	
Blurry or Fluctuating Vision	N Y	
Glare or light sensitivity	N Y	
Itching / Burning / Dryness /Redness	N Y	
Excess tearing/watering	N Y	
Floaters / Flashes of light	N Y	
Mucous discharge	N Y	
Foreign body Feeling / Pain/ Soreness	N Y	
Ingrown Eyelashes	N Y	
Other:	N Y	

List All Eye Medications & OTC Drops ☐ *None*		
	R L	X / Day
	R L	X / Day
	R L	X / Day
	R L	X / Day
	R L	X / Day

Ocular History Problems ☐ *None*		**Blood Relative History**
Cataracts	N Y	
Glaucoma	N Y	
Macular Degeneration	N Y	
Retinal Problems / Detachment	N Y	
Corneal Problems	N Y	
Eye Muscle Problems	N Y	
Injury / Trauma	N Y	
Other	N Y	

Past Eye Surgeries ☐ *None*		**Date of Sx**
Cataract Surgery	N Y	
Glaucoma Surgery	N Y	
Retinal Surgery	N Y	
Lid Surgery	N Y	
After Cataract Laser Surgery	N Y	
Lasik / Lasek / PRK / RK / RLE	N Y	
Other	N Y	

MEDICAL HISTORY

	Self	**Family**	**Duration & Treatments**
Cardiovascular	**None**	**None**	
High Blood Pressure	N Y	N Y	
High Cholesterol	N Y	N Y	
Heart Problems	N Y	N Y	
Stroke	N Y	N Y	
Other:	N Y	N Y	
Cancer	**None**	**None**	

How would You Rate Your General Health:
Excellent / Good
Fair / Poor
Constitutional Symptoms:
Fatigue, Fever, Chills
Weight Loss
☐ *None*

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	Self	Family	Duration & Treatments
Endocrine	**None**	**None**	
Thyroid Problems	N Y	N Y	
Diabetes	N Y	N Y	
Pituitary Gland	N Y	N Y	
Hormone Imbalance	N Y	N Y	
	N Y	N Y	
Blood or Lymph System Disorders	**None**	**None**	
Anemia	N Y	N Y	
Leukemia	N Y	N Y	
	N Y	N Y	
Ears, Nose, Throat, Lung	**None**	**None**	
Seasonal Allergies / Sinus Problems	N Y	N Y	
Asthma	N Y	N Y	
Lung Problems	N Y	N Y	
Hearing Loss	N Y	N Y	
	N Y	N Y	
Immunologic	**None**	**None**	
Rheumatoid Arthritis	N Y	N Y	
Lupus	N Y	N Y	
AIDS / HIV	N Y		
Neurologic / Psychiatric	**None**	**None**	
Seizures / Epilepsy	N Y	N Y	
Stroke / Paralysis	N Y	N Y	
Parkinsons / Dementia /Alzheimer	N Y	N Y	
Depression / Schizophrenia	N Y	N Y	
	N Y	N Y	
Skin / Muscles & Bones	**None**	**None**	
Psoriasis / Eczema	N Y	N Y	
Shingles / Herpes	N Y	N Y	
Fibromyalgia	N Y	N Y	
Osteoporosis	N Y	N Y	
Gastrointestinal Genitourinary /	**None**	**None**	
Crohn's Disease	N Y	N Y	
Liver Problems	N Y	N Y	
Kidney/Bladder Problem	N Y	N Y	
Prostrate Problems	N Y	N Y	

Prescription & OTC Medications:
☐ *See attached List*
☐ *None*

List All Food & Drug Allergies
☐ *None*

Do You?

Smoke: N Y
How Much:

Drink: N Y
How Much

Use Recreational Drugs: N Y
Explain:

Social History

Recent Overseas Trip: N Y

Toxic Exposures: N Y

Patient Signature: ***Date:*** ***Doctors Signature:*** ***Date:***

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Welcome to the Office

Patient Name _____ Male / Female

Date of Birth: ____/____/_____ Age: ____ Single / Married / Partnered / Widow (er) / Divorced / Separated

Social Security #: _____ Spouse Name: _____

Parent's Name (If under 18 years old) : _____

Your Address: _____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

How do you prefer to be contacted?
Home / Work / Cell
Text / Email / Mail

In case of emergency: _____ Phone: _____

Primary Care Physician (PCP): _____

City & State of PCP: _____ Phone # of PCP: _____

My Primary Insurance is: _____ Policy #: _____

My Secondary Insurance is: _____ Policy #: _____

Occupation / Employer: _____

Hobbies & Interests: _____

Are you interested in: Contact Lenses Y N Refractive Surgery (Lasik) Y N

How did you hear about us?

1. I was referred by: _____
2. Through my insurance, which is: _____
3. Zoc Doc: **Y N**
4. I found you myself, here's how: _____

_____

At any point in your decision making process, did you:
(Check all that apply)

____ Visit our website
____ Visit our Facebook page
____ Search for us on Zoc Doc
____ Search for us on your insurance website
____ Search for us on Google, Yahoo or Bing
____ Visit our Yelp Page
____ Read any online reviews

Signature: _____ Date: _____

THANK YOU!

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Notice of Privacy Practices – *Short Form*

Our practice is committed to educating our patients about healthcare issues that affect them.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gave the federal government the ability to mandate how healthcare plans, providers and clearinghouses store and send a patient's personal information as it relates to their healthcare.

The Privacy Rule was created to protect your rights as a patient. As of April 4, 2003 all practices were required by law to be compliant with this regulation. Under the Privacy Rule you are:

- Guaranteed access to your medical records
- Allowed control over how your Protected Health Information (PHI) is used and disclosed
- Allowed to take action if your privacy is compromised.

Ft. Lauderdale Eye Associates is dedicated to maintaining the privacy of your personal information. We are providing you with general information about the Privacy Rule. For your convenience, this is a shortened version, highlighting the most important points. You may download our complete version at www.ftleye.com or ask our receptionist for a written copy.

What is Individually Identifiable Health Information (IIHI)?

IIHI is any information that is created and retained by Ft. Lauderdale Eye Associates or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual, including your mailing address.

What is Notice of Privacy Practice?

Ft. Lauderdale Eye Associates has an official *Notice of Privacy Practice* informing patients about their rights surrounding the protection of their IIHI and our obligation concerning the use and disclosure of their IIHI. This notice applies to all records created or retained by Ft. Lauderdale Eye Associates. We reserve the right to change our practices and procedures in our *Notice of Privacy Practice*. If changed, we will issue a revised *Notice of Privacy Practices*. Those changes may apply to any of our protected health information that we maintain. You can ask for a copy of this notice from the receptionist or download it off our website, www.ftleye.com.

The following categories describe the different ways in which we may use and disclose your IIHI:

• *Treatment* • *Appointment Reminders* • *Payment* • *Treatment options*	• *Release of information to family /friends* • *Disclosures required by law* • *Health care operations* • *Health-related benefits and services*

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The following categories describe unique situations in which we may use or disclose your IIHI.

• *Public Health risks* • *Law enforcement* • *Research* • *Correctional institutions* • *Military* • *Workers compensation*	• *Health oversight activities* • *Deceased patients* • *Lawsuits and similar proceedings* • *Organ and tissue donation* • *Serious threats to health or safety*

Your rights regarding the Individually Identified Health Information (IIHI) that we maintain about you are listed in their entirety in our *Notice of Privacy Practices*.

Below are the general headings you may refer to in our complete *Notice of Privacy Practices* for more information:

• *Confidential Communications* • *Requesting Restrictions* • *Inspection and Copies* • *Amendment*	• *Accounting Disclosures* • *Right to a Paper Copy of the Notice* • *Right to File a Complaint* • *Right to Provide and Authorization for Other Uses and Disclosures.*

Please do not hesitate to ask us any questions regarding this notice.

Consent:

I have read the shortened version of the *Notice of Privacy Practices* provided by Ft. Lauderdale Eye Associates and have had full opportunity to read and consider the contents of this consent form. I understand that by signing this consent I acknowledge receipt of the *Notice of Privacy Practices* and I am giving my permission for use and disclosure of my Protected Health Information (PHI) to carry out treatment and payment activities related to my healthcare.

Printed Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____

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Financial Agreement

Ft. Lauderdale Eye Associate's goal is to provide and maintain a good physician-patient relationship. Advising you of our office policies in advance allows for improved communication and enables us to achieve a common goal. Please read this policy carefully. If you have any questions, do not hesitate to ask our staff. Thank you in advance.

- It is your responsibility to understand your health insurance plan benefits (i.e. **HMO**, **PPO**, **Network**) regarding all services. If your physicians are out of the network or you do not have insurance, payment is due in full, at the time of service.
- According to your insurance plan, you are responsible for any co-payments, deductibles/coinsurances (**due at time of service**) and any amount considered non-covered by your insurance carrier (**an estimated amount will be determined prior to service**).
- In an effort to serve you better, we require a 24-hour notice for cancelling appointments, otherwise a $25.00 fee **may** be charged.
- A **REFRACTION** (i.e. eyeglass prescription) is typically not covered by medical insurance. This is a **$55.00** charge, due at the time of service, even when it is necessary for medical treatment. If you would like to opt out of this test, please let the technician know at the beginning of your exam.

Claim Assignment Authorization:

I have read and understand this financial agreement. I authorize my insurance to make payment of medical benefits to the attending Physician for services rendered.

Patient Name: _____

Patient or Responsible Party Signature: _____ Date: _____