ST. JOHNS EYE CARE

ACKNOWLEDGEMENT OF RECEIPT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. ***The Notice of Privacy Practices is furnished in the red folders in our lobby*** describes these uses and disclosures in detail. If you would like to take a copy home with you please ask one of our staff members.

I acknowledge that I have been provided the Notice of Privacy Practices from St. Johns Eye Care.

_____
Patient Name

_____ _____ _____
Patient/Guardian Signature Date Guardian Relationship to Patient

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to St. Johns Eye Care on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____
Patient Name

_____ _____ _____
Patient/Guardian Signature Date Guardian Relationship to Patient

Turn me over

FINANCIAL INFORMATION

I acknowledge full responsibility for the payment of services given to me and agree to pay them in full at the time of service, unless other arrangements are made in advance with the office. NOTE: As a courtesy to our patients, we will be glad to submit primary and secondary insurance unless you instruct us not to.

I understand and agree that health insurance policies are an arrangement between the INSURANCE CARRIER AND MYSELF. I understand and agree that it is my responsibilty to pay any deductible amount, co-insurance, or non-covered services.

When Charges are filed with your insurance carrier and notice of benefits is not received by our office within 60 days, all fees become the patient's responsibilty. Interest may accrue at a rate of 18% on all balances over 120 days old. In the event that your account has to be turned over to collections, you will be responsible for any and all collection fees.

No refunds are given on glasses or contacts already made by our laboratory, remake or exchange only. All orders not dispensed within 30 days of notification will forfeit deposit unless prior arrangements are made. We are not responsible for products left over 90 days.

My signature below attests to the fact that I have read and do understand the above mentioned policies. This signature also authorizes the release of any information necessary to secure payment. A photocopy of this signature is as valid as an original.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

_____ _____
Print/Guardian Name Relationship to Patient

St. Johns Eye Care
2504 Crill Avenue • Palatka, FL 32177
(386) 328-5141

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be here to help you.

PATIENT INFORMATION

Patient _____

Mailing Address _____

_____
City State Zip

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Driver's License _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary _____

Policy # _____ Group # _____

Policy Holder _____ Birthdate _____

Relationship to Patient? _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Insurance Co. _____

Policy # _____ Group# _____

_____
Responsible Party Signature Date

Whom may we thank for referring you?

ASSIGNMENT AND RELEASE I the undersigned, certify that I (or my dependent) assign directly to St. Johns Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

EYE HEALTH HISTORY

Date of last eye exam _____ By whom _____

Do you wear glasses or contacts: ❑ Yes ❑ No Type _____

	Yourself		Family		Yourself		Family
Bloodshot Eyes	❑ Yes	❑ No	_____	Floaters or Spots	❑ Yes	❑ No	_____
Blurred Vision–Distance	❑ Yes	❑ No	_____	Headaches	❑ Yes	❑ No	_____
Blurred Vision–Near	❑ Yes	❑ No	_____	Itching Eyes	❑ Yes	❑ No	_____
Burning eyes	❑ Yes	❑ No	_____	Light Sensitive	❑ Yes	❑ No	_____
Color Vision, Poor	❑ Yes	❑ No	_____	Night Vision, Poor	❑ Yes	❑ No	_____
Crossed Eyes	❑ Yes	❑ No	_____	Red Eyes	❑ Yes	❑ No	_____
Discharge from Eyes	❑ Yes	❑ No	_____	Seeing halos	❑ Yes	❑ No	_____
Dizzy Spells	❑ Yes	❑ No	_____	Seeing Flashes	❑ Yes	❑ No	_____
Double Vision	❑ Yes	❑ No	_____	Temporary loss of Vision	❑ Yes	❑ No	_____
Dry Eyes	❑ Yes	❑ No	_____	Twitching Eyelid	❑ Yes	❑ No	_____
Eye Infection	❑ Yes	❑ No	_____	Vision Poor	❑ Yes	❑ No	_____
Eye Injury	❑ Yes	❑ No	_____	Watering Eyes	❑ Yes	❑ No	_____
Eye Strain	❑ Yes	❑ No	_____	Lazy Eye	❑ Yes	❑ No	_____
Fainting Spells, Blackouts	❑ Yes	❑ No	_____	Drooping Eye	❑ Yes	❑ No	_____

Medical History & ROS from ___/___/___ reviewed: no changes

_____
O.D. Initials

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I prefer to speak directly with my doctor.

Do you drive? ❑ No ❑ Yes If so, do you have difficulty when driving? _____

Do you use tobacco products? ❑ No ❑ Yes Do you drink alcohol? ❑ No ❑ Yes

Do you use illegal drugs? ❑ No ❑ Yes Are you pregnant or nursing? ❑ No ❑ Yes

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

EYES
- Loss of Side Vision ❑ Yes ❑ No
- Mucous Discharge ❑ Yes ❑ No
- Sandy or Gritty Feeling ❑ Yes ❑ No
- Foreign Body Sensation ❑ Yes ❑ No
- Eye Pain or Soreness ❑ Yes ❑ No
- Sties or Chalazion ❑ Yes ❑ No
- Tired Eyes ❑ Yes ❑ No

ENDOCRINE
- Thyroid / Other Glands ❑ Yes ❑ No
- ❑ Yes ❑ No

RESPIRATORY
- Asthma ❑ Yes ❑ No
- Chronic Bronchitis ❑ Yes ❑ No
- Emphysema ❑ Yes ❑ No

LYMPHATIC / HEMATOLOGIC
- Anemia ❑ Yes ❑ No
- Bleeding Problems ❑ Yes ❑ No

CONSTITUTIONAL
- Fever ❑ Yes ❑ No
- Weight Loss / Gain ❑ Yes ❑ No

INTEGUMENTARY (Skin) ❑ Yes ❑ No

NEUROLOGICAL
- Headaches ❑ Yes ❑ No
- Migraines ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No

EAR, NOSE, MOUTH, THROAT
- Allergies / Hay Fever ❑ Yes ❑ No
- Sinus Congestion ❑ Yes ❑ No
- Runny Nose ❑ Yes ❑ No
- Post-Nasal Drip ❑ Yes ❑ No
- Chronic Cough ❑ Yes ❑ No
- Dry Throat / Mouth ❑ Yes ❑ No

VASCULAR & CARDIOVASCULAR
- Diabetes ❑ Yes ❑ No
- Heart Pain ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No
- Vascular Disease ❑ Yes ❑ No

GASTROINTESTINAL
- Diarrhea ❑ Yes ❑ No
- Constipation ❑ Yes ❑ No

GENITOURINARY
- Genitals / Kidney / Bladder ❑ Yes ❑ No

BONES / JOINTS / MUSCLES
- Rheumatoid Arthritis ❑ Yes ❑ No
- Muscle Pain ❑ Yes ❑ No
- Joint Pain ❑ Yes ❑ No

ALLERGIC / IMMUN. ❑ Yes ❑ No

PSYCHIATRIC ❑ Yes ❑ No

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

List any allergies to any medications:

_____

_____

_____

_____

_____

Primary Care Physician & Phone Number _____

I authorize St. Johns Eye Care to use the following contact numbers to reach me, if I cannot be reached I give my authorization to leave a message with a family member or an answering machine.

_____ _____

Phone Number #1 Phone Number #2

_____

Signature

Is there anything else you would like to inform our office about? _____

_____

_____

_____

Thank You

_____

Doctor Signature