

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ Physician Phone: (\_\_\_\_) \_\_\_\_\_  
Spouse / Parent / Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

How would you prefer to be reminded of your appointments (Please check all that apply)?  Phone  Text  Email

**Whom May We Thank for Referring You?** \_\_\_\_\_

**INSURANCE**

Medical Insurance Plan: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Vision Insurance Plan: \_\_\_\_\_ ID#: \_\_\_\_\_  
Primary Insured Name: \_\_\_\_\_ Primary Insured Birthdate: \_\_\_\_\_

Date Last Eye Exam: \_\_\_\_\_ By Whom: \_\_\_\_\_ Date Last Medical Exam: \_\_\_\_\_ By Whom: \_\_\_\_\_

Medications: \_\_\_\_\_

Any Allergies: \_\_\_\_\_

Do you wear glasses?  Yes  No How old are your glasses? \_\_\_\_\_

**CONTACTS**

Do you wear contacts?  Yes  No What Brand? \_\_\_\_\_ What solution do you use? \_\_\_\_\_

Power of your contacts: Right: \_\_\_\_\_ Left: \_\_\_\_\_ What do you dislike about your contacts? \_\_\_\_\_

How often do you replace your contacts? \_\_\_\_\_ How often do you sleep in your contacts? \_\_\_\_\_

**MEDICAL HISTORY**

Do you smoke?  Yes  No Do you drink Alcohol?  Yes  No  Only Socially

Are you Pregnant?  Yes  No Are you Nursing?  Yes  No

**MEDICAL AND OCULAR HISTORY- Please CHECK Yes or No for Yourself & Note any Family History**

	YES	NO	Year Diagnosed	Family		YES	NO	Year Diagnosed	Family
High Blood Pressure					Eye Injury: _____				
Diabetes (Insulin, pills, diet cc)					Eye Surgery: _____ (Including laser)				
Thyroid					Cataracts				
High Cholesterol					Cataract Implants				
Heart Disease					Glaucoma				
HIV/ AIDS					Macular Degeneration				
Hepatitis					Crossed Eyes or Double Vision				
Arthritis					Lazy Eye (Amblyopia)				
Cancer					Floaters or Flashing Lights				
Sinus					Blindness				
Allergies					Dry Eyes				
Headaches					Eye Pain				
Other: _____					Other: _____				

What is the reason for your visit today? \_\_\_\_\_

# SeaView Eyecare

## Receipt of Notice of Privacy Practices & Practice Policies Written Acknowledgment Form

By signing below I acknowledge that I have had the opportunity to read and understand SeaView Eyecare's HIPAA Notice of Privacy Practices and Practice Policies.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or guardian

\_\_\_\_\_  
Date

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

### Retinal Imaging

For a more complete exam, and to monitor for changes in ocular health from year to year, our doctors require annual retinal imaging for all patients at every age. Insurance companies consider this imaging preventative and do not provide full coverage for it. The fee for this imaging is \$39 and it will be added to your exam fee or copay for all annual routine exams. According to Florida State Law, retinal imaging cannot be substituted for dilation; rather the two methods of examination complement one another to provide a more comprehensive evaluation of the health of the eyes.

### Dilated Exam

The purpose of dilating your pupils is to perform a more thorough examination of the health of your eyes. This allows the doctor to view the peripheral retina, a part of the eye not visible without dilation. Individuals with diabetes, glaucoma, high prescriptions, systemic disease and those over 55 years old are strongly encouraged to have a dilation annually. All others should be dilated every 1-2 years. The side effects of dilation may include blurred vision, light sensitivity and stinging upon installation of the drops.

- I have read the previous statement and **ACCEPT** a dilated exam
- I have read the previous statement and **DECLINE** a dilated exam
- I have read the previous statement and **DEFER** dilation. I will return within one month for my \_\_\_\_\_ dilation

\_\_\_\_\_  
\_\_\_\_\_