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
High Blood Pressure				
Diabetes (Insulin, pills, diet co				
Thyroid				
High Cholesterol				
Heart Disease				
HIV/ AIDS				
Hepatitis				
Arthritis				
Cancer				
Sinus				
Allergies				
Headaches				
Other:_____				

	YES	NO	Year Diagnosed	Family
Eye Injury:_____				
Eye Surgery:_____ (Including laser)				
Cataracts				
Cataract Implants				
Glaucoma				
Macular Degeneration				
Crossed Eyes or Double Vision				
Lazy Eye (Amblyopia)				
Floaters or Flashing Lights				
Blindness				
Dry Eyes				
Eye Pain				
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

_____

_____