Welcome To Our Office

Name:_____
(Last) (First) (Middle) (Date)

Address:_____
(Street) (City) (State) (Zip Code)

Home Phone: (_____)_____Work Phone: (_____)_____DOB:_____

Email:_____

Sex:_____Weight:_____Ht:_____Family Physician:_____

Occupation:_____Primary Language:_____

Date of last eye exam:_____By Whom:_____

Reason for today's exam:_____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

Name:_____
(Last) (First) (M.I.)

Address:_____
(Street) (City) (State) (Zip Code)

INSURANCE INFO

Primary Insurance:_____

Insurance ID#:_____

Informed Consent for Dilation

I am aware that dilation drops could result in the following; blurry vision, sensitivity to light, inability to judge distance, imbalance. You may elect to schedule a dilation at a later time. I have read and understand the risk referred to the above and hereby consent to having my eyes dilated.

Notice of Privacy Practices

As of April 14, 2003 a new law took effect called the Health Insurance Portability and Accountability Act, Referred To As "HIPAA". Part of the law protects you against the unauthorized use of your personal medical files. A copy of the HIPAA law is available upon request.

Assignment of Benefits Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. William A. Olivos for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. William A. Olivos to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. I have requested medical services from Dr. William A. Olivos on behalf of myself and/or my dependents, and understand that by making this request, I become financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature_____Date_____

COMPLETE MEDICAL HISTORY

SOCIAL HISTORY

1. Do you wear glasses? Y N If so how long?_____
2. Do you drink alcohol? Y N If so how much?_____
3. Do you smoke now? Y N If so how much?_____
4. Do you live alone? Y N
5. Do you wear contacts? Y N

EYE HISTORY–Do you, any of your relatives or family members have the following?:

Blindness_____ Eye Surgery_____
Cataracts_____ Glaucoma_____
Corneal Diseases_____ Macular Degeneration_____
Diabetes_____ Retinal Disease_____

COMMENTS:_____
ALLERGIES TO MEDICATIONS:_____
MEDICATIONS:_____
ASPIRIN PRODUCTS:_____
Previous surgeries/hospitalizations? Y N
Procedure: List any other serious illness or accidents not listed above:_____
_____

CHEST/LUNGS

Asthma _____
Chronic Cough_____
COPD _____
Emphysema_____
Shortness of Breath_____
Other _____

HEART/CARDIOVASCULAR

Anginal syndrome _____
Bleeding Disorders _____
Cardiac Arrhythmia _____
Circulation Problems _____
Congestive Heart Failure_____
Heart Attack_____
High Blood Pressure _____
Other _____

ABDOMEN

Bladder Infection _____
Bowel/Intestinal Problem_____
Chronic Liver Disorder_____
Liver Disease_____
Gall Bladder Problem _____
Hepatitis_____
Kidney Infection_____
Kidney Stones _____
Nausea/Vomiting _____
Prostate Disorders_____
Renal Disease _____
Stomach Problems _____
Ulcers _____
Urinary Problems_____
Uterine Disorders_____
Other _____

HEENT

Dental Problems _____
Sinus Problems _____
Hearing Loss _____
Other _____

EXT/NEUROLOGICAL

Arthritis _____
Convulsions_____
Cramping/Pain in Leg _____
Fractures _____
Headaches _____
Joint Replacement_____
Nerve Palsy _____
Phlebitis_____
Previous Stroke _____
Rheumatism _____
Rheumatic Diseases _____
Shingles_____
Other _____

OTHER

Bleeding Tendency _____
Bruising Tendency _____
Cancer_____
Diabetes _____
Dizziness _____
Fainting _____
Hormone Imbalance _____
Immune Deficiency _____
Psychiatric Episodes _____
Thyroid Disease_____
Other _____

BOTH PAGES OF HISTORY REVIEWED_____
(Physicians Initials

ADVANCED EYE CARE CENTER

4976 South 25th Street
Fort Pierce, FL 34981

2710 SW Port St. Lucie Blvd
Port St. Lucie, FL 34953

PATIENT AUTHORIZATION FORM

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request results of tests, procedures, and financial information. Under the requirements for H.I.P.A.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Advanced Eye Care Center to release my records and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages
(Check all that apply)

___ I authorize you to leave a detailed message on my home or cellphone regarding appointments

___ I authorize you to leave a detailed message on my home or cellphone regarding medical treatment, care, test results or financial information.

___ I authorize you to leave a message with anyone who answers the phone
___ Message are to be left with _____

_____ _____

PATIENT NAME (PLEASE PRINT) **DATE**

_____

PATIENT SIGNATURE