Central Florida Retina

Patient Information Form

Date _____

Patient Information

First Name _____ MI _____ Last Name _____

Street Address _____ P.O. Box (if any) _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Email _____ Social Security # _____

Date of Birth _____ Age _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Sex: ☐ Male ☐ Female

Emergency Contact _____ Phone _____ Relation _____

Your Employer _____ Occupation _____

Address, City, Zip _____ Phone ( ) _____

Physicians

Primary Care Physician _____ Phone ( ) _____

Endocrinologist _____ Phone ( ) _____

Cardiologist: _____ Phone ( ) _____

Nephrologist: _____ Phone ( ) _____

Other: _____ Phone ( ) _____

Referral Source

☐ Family or Friend: _____ ☐ Online: _____

☐ Doctor: _____ ☐ Other: _____

Central Florida Retina

Insurance & Financial Policy

Date _____

Insurance Information

Primary Insurance _____

Policy Holder Name _____ Policy Holder DOB _____

Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependant

Secondary Insurance _____

Policy Holder Name _____ Policy Holder DOB _____

Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependant

Financial Responsibility

Who will be financially responsible for any balance you may incur?

☐ Self ☐ Spouse ☐ Parent ☐ Employer

☐ Other: _____

Patient Agreement

By signing the below, I indicate that I understand and will comply with the above.

Patient/Representative Signature _____ Date _____

Print Name _____ Representative Relation to Patient _____

Central Florida Retina

Patient History

Name _____ Date _____

Medical & Family History

Please check the following if they apply to **yourself (S)** or an immediate **family member (F)**.

S	F		S	F		S	F	
		Allergies			Depression			Hypertension
		Angina			Diabetes ☐ Type I ☐ Type II			Irritable Bowel Syndrome
		Anxiety			Elevated Lipids			Myocardial Infarction
		Arthritis			Gall Bladder Disease			Osteoporosis
		Asthma			GERD			Renal Disease
		Atrial Fibrillation			Headache, Migraine			Seizure Disorder
		Benign Prostate Hypertrophy			Heart Disease			Stroke
		Bypass			Heart Stent			Tuberculosis
		Cancer			Heart Valve Disorder			Thyroid Disease
		Cardiac Arythmia			Hepatitis/Liver Disease			Other:
		COPD			HIV			

Ocular History

Y	N	TYPE	WHICH EYE	DATE	SURGEON
		Cataract Surgery			
		Yag Laser			
		Glaucoma			
		Retina Surgery			
		Injections			
		Other:			

Previous Surgeries (including dates):

Medications (including dosages):

Allergies:

Social History (If yes, please explain)

Do you drink alcohol? ☐ No ☐ Yes _____

Have you ever used tobacco products? ☐ No ☐ Yes _____

Caffeine use? ☐ No ☐ Yes _____

Any use of street drugs? ☐ No ☐ Yes _____

Central Florida Retina

Patient Authorization Form

Name _____ Date _____

Authorization to Access & Update Medication List

I authorize Central Florida Retina to obtain a list of my medications from my primary pharmacy through electronic data capture. I also give CFR permission to periodically update medications that might be prescribed to me in the future.

Pharmacy _____ Phone _____

Address (Street) _____

Address (City, State, Zip) _____

Patient Signature _____

Authorization to Release Health Information

I **authorize** Central Florida Retina/Ophthalmic Partners of Florida to release personal health information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____

Is there anyone that **should not** see your personal health information?

☐ No ☐ Yes:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____

Central Florida Retina

Patient Consent Form

Name _____ Date _____

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Submission of Consent

You are entitled to a copy of this consent after you sign it.

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am authorizing Central Florida Retina to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature _____

If you are signing as a personal representative on behalf of the patient, please complete the following:

Personal Representative _____ Relation _____

Revocation of Consent

I revoke my consent for you to use and disclose my personal health information for treatment, payment activities and health care operations. I understand the revocation of my consent will not affect any action Central Florida Retina took in reliance of my consent before they received this written Notice of Revocation. I also understand CFR may decline to treat or continue to treat me after I have revoked my consent.

Signature _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read and/or received a copy of this Notice of Privacy Practices.

Signature _____

For Office Use:

- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining the agreement
- ☐ Other: _____