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: ______________

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 ________________

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 ______________________

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 ______________________

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: ______________________