DELRAY EYE ASSOCIATES

PLEASE PRINT: PATIENT INFORMATION

1. Patient Name: ____
   Last First Middle
2. Date of Birth: ____________________ Age: ______ Sex: ______ Marital Status: ____________
3. Address: ______________________________ City: _______________State: ____ ZIP: _______
4. Home Phone #: _________________________ Cell #: __________________________________
5. E-Mail Address: ____
6. Social Security #: ______________________________ Occupation: _______________________
7. Employer: __________________________________ Employer's Phone #: __________________
8. Employer's Address: ______________________City: ______________ State: _____ZIP: _______
9. Spouse or Parents Name: ____
10. Employer: __________________________________ Employer's Phone #: __________________
11. Employer's Address: ______________________City: ______________ State: _____ZIP: _______
12. Person to contact in case of emergency: _____________________________Phone #: ____________
13. Referred by: ____ Today's Date: _______________

Insurance Information: **Are you a member of an HMO? Yes No**
(Health Maintenance Organization)

1. Medicare or Primary Insurance ___________________________ Phone #: ____________________
2. Address: _____________________________City: _______________State: ________ Zip: ______
3. Name of Insured: ____________________________ Social Security #: ______________________
4. Policy #: ___________________________ Group #: _____________________ D.O.B. _________
5. Secondary Insurance: ___________________________________ Phone #: ____________________
6. Address: _____________________________ City: ______________ State: _________ Zip: _____
7. Name of Insured: ____________________________ Social Security #: ______________________
8. Policy #: ___________________________ Group #: _____________________ D.O.B.__________

PLEASE PRESENT INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPY

LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release the Health Care Financing Administration and its agencies, any information needed to authorize these benefits or the benefits payable for related services. I request that payment of authorized Medicare insurance benefits be made on my behalf to Dr. Rosenfeld, Dr. Kronish, Dr. Schaffer, Dr. Jewelewicz, Dr. Winnick, Dr. Gonzalez, Dr. Glatzer, Dr. Werner, Dr. Saitowitz, and Delray Eye Associates, P.A., for any services furnished me by those physicians. I also agree that any and all balance will be paid by me, and that photocopies of this form will be valid. I request that this information also apply to all other insurance. I understand that I am financially responsible for all charges, whether or not paid by the insurance carrier.

Signed: ____ Date: ________________________

PtRegistrationForm/revised 8/2018

NOTICE OF PRIVACY PRACTICES FOR DELRAY EYE ASSOCIATES, P.A.

THIS NOTICE SUMMARIZES OUR *Health Insurance Portability and Accountability Act* POLICY CONCERNING HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as name, address, phone number, medical information, etc. We may also electronically obtain your personal medication history to assist in your treatment.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for treatment, for consultation with ʾther health-care professionals, for payment from insurance companies, when required to by law, and for various other reasons which are fully explained in our complete HIPAA policy statement, *which is available to you upon request, and which we strongly urge you to review. There is a fee associated with providing you with a full copy.*

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time.

I authorize you to discuss my medical records and care with the following:

____

____

'NDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it. To exercise any of your rights, please contact us in writing at:

Leslie Bardt Buchanan
Practice Administrator
Delray Eye Associates, P.A.
16201 South Military Trail
Delray Beach, FL 33484

A COPY OF OUR COMPLETE HIPAA POLICY IS AVAILABLE FOR YOUR REVIEW. THERE IS A FEE ASSOCIATED WITH PROVIDING A COMPLETE COPY.

Patient signature ____

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Patient History Questionnaire

Name ____________________ Date of Birth ____________________

Primary Physician: ____________________ Address: ____________________

Previous Ophthalmologist: ____________________ Address: ____________________

Referring Physician: ____________________ Address: ____________________

Current Medications: ____________________

____

Allergies to Medication

List all allergies to medications: ____________________

____

Review of Systems:

Please check **YES** or **NO** in bold boxes. If yes, specify in small boxes and explain.

Constitutional Symptoms	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Other	☐	☐	______

Eye	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Blurry Vision	☐	☐	______
Burning	☐	☐	______
Chronic infection of eyes or lids	☐	☐	______
Distorted vision	☐	☐	______
Double vision	☐	☐	______
Dryness	☐	☐	______
Excess tearing/watering	☐	☐	______
Fluctuating visual acuity	☐	☐	______
Foreign body sensation	☐	☐	______
Glare/light sensitivity	☐	☐	______
Itching	☐	☐	______
Loss of side vision	☐	☐	______
Mucous discharge	☐	☐	______
Occasional tearing	☐	☐	______
Pain or soreness	☐	☐	______
Redness	☐	☐	______
Sandy or gritty feeling	☐	☐	______
Sty, Chalazion	☐	☐	______
Tired eyes	☐	☐	______
Other	☐	☐	______
Are you having any difficulty?			
Reading small print	☐	☐	______
Reading in general	☐	☐	______
Recognizing people when close	☐	☐	______

Eyes continued	**YES**	**NO**	Explanation of problem
Seeing to go up and down steps or curbs	☐	☐	______
Driving in bright light	☐	☐	______
Driving in the dark	☐	☐	______
Reading street/traffic signs	☐	☐	______
Doing fine handiwork	☐	☐	______

Writing (checks, cards, etc	☐	☐	______
Playing games (bingo, cards, etc.)	☐	☐	______
Playing sports (golf, tennis)	☐	☐	______
Doing hobbies	☐	☐	______
Watching TV/Movies	☐	☐	______
Are you satisfied with your current vision?	☐	☐	______
Other			

Eye History	**YES**	**NO**	**When Diagnosed**	**Treatment**
Cataract	☐	☐	______	______
Glaucoma	☐	☐	______	______
Eye muscle problems	☐	☐	______	______
Retina Problems	☐	☐	______	______
Corneal Problems	☐	☐	______	______
Injury	☐	☐	______	______
Night Blindness	☐	☐	______	______
Other	☐	☐	______	______

Current Eye Medications: ______

______

Past Eye Surgery	**Date**
Operation(s)/Laser Treatment(s) ______	______
______	______
______	______

Ear, Nose, Mouth, Throat	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Sinus congestion/Post-nasal drip	☐	☐	______
Difficulty swallowing	☐	☐	______
Pain chewing	☐	☐	______
Chronic cough	☐	☐	______
Dry throat/mouth	☐	☐	______
Other	☐	☐	______

Cardiovascular	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Congestive heart failure	☐	☐	______
Heart murmur/Mitral valve prolapse	☐	☐	______
Heart attacks	☐	☐	______
Other	☐	☐	______
Open heart surgery/Angioplasty (describe)	______		

Respiratory (Lungs/Breathing)	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Shortness of breath	☐	☐	______
Tuberculosis	☐	☐	______
Lung cancer	☐	☐	______
Sarcoidosis	☐	☐	______
Other	☐	☐	______
Surgery	______		

Gastrointestinal (Stomach/Intestines)	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Jaundice/Hepatitis	☐	☐	______
Ulcers/Bleeding	☐	☐	______
Hiatal Hernia	☐	☐	______

Cancer.. ☐ ☐ ________________
Other.. ☐ ☐ ________________
Surgery ________________

Genitourinary (Genitals/Kidney/Bladder).... **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Kidney disease...................................... ☐ ☐ ________________
Prostate cancer...................................... ☐ ☐ ________________
Cervical/Uterine/Ovarian/Breast Cancer.......... ☐ ☐ ________________
Pregnant now?...................................... ☐ ☐ ________________
Surgery ________________

Integumentary (Skin and/or breast)......... **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Skin disease/cancer.................................. ☐ ☐ ________________
Breast disease/cancer............................... ☐ ☐ ________________
Shingles... ☐ ☐ ________________
Other.. ☐ ☐ ________________
Surgery ________________

Musculo-Skeletal.............................. **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Arthritis.. ☐ ☐ ________________
Broken bones....................................... ☐ ☐ ________________
Scalp tenderness.................................... ☐ ☐ ________________
Cancer.. ☐ ☐ ________________
Other.. ☐ ☐ ________________
Surgery ________________

Neurological.................................. **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Fainting.. ☐ ☐ ________________
Convulsions/Seizures/Epilepsy.................. ☐ ☐ ________________
Stroke/Paralysis.................................. ☐ ☐ ________________
Benign tumor...................................... ☐ ☐ ________________
Cancer.. ☐ ☐ ________________
Alzheimer's.. ☐ ☐ ________________
Other.. ☐ ☐ ________________
Surgery ________________

Psychiatric.................................... **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Schizophrenia...................................... ☐ ☐ ________________
Other.. ☐ ☐ ________________

Hematologic/Lymphatic.................... **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Anemia... ☐ ☐ ________________
Sickle cell disease................................ ☐ ☐ ________________
Leukemia/Blood cancer......................... ☐ ☐ ________________
Lymphoma... ☐ ☐ ________________
Swelling... ☐ ☐ ________________
Enlarged lymph nodes........................... ☐ ☐ ________________
Surgery ________________

Allergic/Infectious............................ **YES** **NO** (If no, proceed to next topic)
Explanation of problem

Head allergy symptoms	❑	❑	______
Hay fever symptoms	❑	❑	______
Immune problems	❑	❑	______
HIV/AIDS	❑	❑	______
Lyme disease	❑	❑	______
Other	❑	❑	______
Surgery			______

Endocrine	**YES**	**NO**	(If no, proceed to next topic) Explanation of problem
Diabetes	❑	❑	______
Cancer-pancreas/adrenal glands	❑	❑	______
Thyroid problems	❑	❑	______
Thyroid cancer	❑	❑	______
Hormone replacement therapy	❑	❑	______
Other	❑	❑	______
Surgery			______

Other

______ ______

______ ______

______ ______

Past Social History

Past History

Describe any other problems, illnesses, surgeries, or medicines that were not described in the above questions.

______

______

Social History	**YES**	**NO**	**Explanation**
Toxic exposures	❑	❑	______
Recent voyages	❑	❑	______
Other	❑	❑	______

Date ______ Patient Signature ______

Date ______ Physicians Signature ______

Rosenfeld Kronish Schaffer Jewelewicz Winnick Glatzer Werner Smith Saitowitz