Treasure Coast Eye Specialists
514 SW Prima Vista Blvd.
Port Saint Lucie, FL 34983
Phone: (772) 878-3437
Fax: (772) 878-1298

Dear

Welcome to our practice. We are very pleased that you have selected us for your eye care needs. We look forward to meeting you and providing you with personal and quality care. We pride ourselves on trying to make your eye care and treatment a pleasant experience.

Please fill out the enclosed forms, checking that all sections are completed, and bring them with you to your visit. Please make sure to bring your current glasses and contact lenses with you to your appointment, as well as all of your eye medications, in a bag.

If you have any questions, please do not hesitate to contact us at (772)878-3437 so that we may assist you.

Thank you for choosing Treasure Coast Eye Specialists(P) to take care of your ocular health.

We look forward to seeing you.

Sincerely,

Directions To the Port St. Lucie Office

Our office is located between Bayshore Blvd and Airoso Blvd, on the south side of Prima Vista Blvd

From the SOUTH (traveling NORTH on US1): Make a LEFT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

From the NORTH (traveling SOUTH on US1): Make a RIGHT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

FROM I-95: *(St. Lucie West Blvd becomes Prima Vista Blvd and you cross Bayshore Blvd)* Take EXIT 121, which is St. Lucie West Blvd. Head EAST 3 miles (you will cross over the turnpike). After you pass the Bayshore/ Prima Vista intersection, you will travel .6 of a mile and the parking lot entrance will be on the RIGHT.

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TREASURE COAST
EYE SPECIALISTS

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name				**Salutation**	
Date of Birth		**Age**			
Gender				**SS #**	
Address					

****Do you have a secondary address? □ YES or □ NO**
If yes, please write it on the back of this paper.

Communication					
Preference					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			
Please Check: **I give permission to leave voicemail on:**	[ ] Home Phone [ ] Cell Phone [ ] Work Phone **OR** [ ] No Voicemail	**Please Check:**	[ ] I give permission to communicate with me via email and/or text message using the information I have provided. [ ] I understand that email and text message is not a secured medium for transmitting personal health information.		

Information			
Primary Language (Please circle)	English Spanish French Italian Other:	**Marital Status (Please circle)**	Single Married Widowed Divorced Other:
Race- (Please circle)	American Indian Asian African American Native Hawaiian other Pacific Islander White Other Race	**Ethnicity (Please circle)**	Non-Hispanic or Latino Hispanic or Latino
Primary Care Physician:		**Who were you referred by?**	

Account Responsible					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone		**Work Phone #**		**Extension**	
Email					

Primary Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			

Primary Insurance			
Insured		**Date of Birth**	
Secondary Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			
Insured		**Date of Birth**	

Emergency Contact							
Sal	**First**	**M**	**Last**	**Relation**	**Home#**	**Cell#**	**Permission to release personal health information**
							[ ] Yes [ ] No

Other Contacts							
Sal	**First**	**M**	**Last**	**Relation**	**Home#**	**Cell#**	**Permission to release personal health information:**
							[ ] Yes [ ] No

Patient Health History

Please review, make necessary changes and supply any missing information.

Review Of Systems	
Please CIRCLE any symptoms that you are experiencing	
General	Appetite Changes, Chills, Fatigue, Fever, Light Headedness, Weakness, Weight Gain, Weight Loss
Cardiovascular	Tightness, Chest Pain, Palpitations, Shortness of Breath, Swelling Hands/ Feet, Sudden Awakening From Sleep with Shortness of Breath
Ears, Nose, Mouth, Throat	Ear Drainage, Hay Fever, Hoarseness, Sore Tongue, Thrush, Non-Healing Sores, Dentures, Dizziness, Earaches, Hearing Loss, Nose Bleeds, Sinus Pain, Sore Throat, Stuffy Nose
Respiratory / Lungs	Cough, Shortness of Breath, Sputum, Wheezing, Coughing up Blood, Painful Breathing
Stomach / Intestines	Change in Appetite, Constipation, Diarrhea, Difficulty Swallowing, Change in Bowel Movements, Heartburn, Jaundice, Nausea
Urinary / Reproductive	Burning or Pain, Blood in Urine, Change in Urinary Strength, Change in Color of Urine, Frequent Urination, Incontinence
Bones / Joints / Muscles	Stiffness, Swelling of Joints, Trauma, Back Pain, Joint Pain, Muscle Pain, Neck Pain
Skin / Hair / Nails	Changes in Color/ Pigmentation, Changes in Nail/ Hair, Dryness, Itching, Lumps, Skin Rashes
Neurological	Headaches, Head Injury, Numbness, Tingling, Tremor, Weakness, Dizziness
Psychiatric	Memory Loss, Anxiety, Depression, Nervousness

Review Of Systems	
Please CIRCLE any symptoms that you are experiencing	
Endocrine / Hormonal	Sweating, Frequent Urination, Thirst, Change in Appetite
Blood / Circulation	Easy Bleeding, Easy Bruising
Allergic / Immunologic	Seasonal Allergies
Other	
OR:	***NOT EXPERIENCEING ANY SYMPTOMS AT THIS TIME***

	PAST MEDICAL HISTORY
PLEASE CIRCLE ANY PREVIOUSLY DIAGNOSED CONDITIONS:	Alzheimer's Disease, Anemia, Aneurysms, Anxiety Disorder, Arthritis, Asthma, Atrial Fibrillation, Bell's Palsy, Bipolar Disorder, Cancer/ Hx of Cancer, Cerebral Palsy, Chronic Heart Failure, COPD, Dementia, Depression, Eczema, Emphysema, Epilepsy, Fibromyalgia, Giant Cell Arteritis, Heart Disease, Hepatitis A B C, Herpes Zoster, High Cholesterol, HIV/ AIDS, Hypertension, Hyperthyroid, Hypothyroid, Kidney Disease, Migraines, Multiple Sclerosis, Muscular Dystrophy, Osteoporosis, Pacemaker/ Defibrillator, Parkinson's Disease, Pneumonia, Polymyalgia Pneumatica, Prediabetes, Rheumatoid Arthritis, Seizure Disorder, Sinusitis, Sjoren's Syndrome, Stroke/ TIA-Previous, Tuberculosis, Ulcers, Vertigo, OTHER: **<u>DIABETES (please circle one below):</u>** **TYPE II-** **INSULIN DEPENDENT** **NON-INSULIN DEPENDENT** **TYPE I-** **INSULIN DEPENDENT** **NON INSULIN DEPENDENT** ***OR PLEASE SELECT:*** **( ) No previously diagnosed conditions**

Diabetic Information		
Type of Test		
SMBS: Self Monitoring Blood Sugar test	**Date of Last Recorded Test**	
	Value	
	Location / Timing	
HgbA1c: Hemoglobin A1c test	**Date of Last Recorded Test**	
	Value	
	Location / Timing	

Surgical Information- Please list all past surgeries				
Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Medications			
Please cross out any medications that you are no longer taking **Please list all prescriptions, over the counter and herbal medications** ****If you are not currently taking any medications, please indicate NONE below:**			
Date	**Name**	**Strength**	**Directions**

Past / Present Ocular History		
Please CIRCLE all that apply and FILL IN any missing information		**Date/ Duration**
Last Eye Exam:	Date:	
Cataracts	YES or NO If Yes, have you ever had any surgery? YES or NO When?	
Glaucoma	YES or NO If yes, have you ever had any surgery? YES or NO When?	
Vision	Vision Loss/ Changes: How long? Blurry/ Double Vision: How long?	
Retinal Disease	YES or NO If yes, have you ever had any surgery? YES or NO When?	
Glasses/ Contacts	YES or NO If yes, how long have you been wearing?	
Pain	YES or NO If yes, how long?	
Redness	YES or NO If yes, how long?	
Flashing Lights	YES or NO If yes, how long?	
Floaters/ Specks	YES or NO If yes, how long?	
Dry Eyes	YES or NO If yes, how long?	
Other:		

Do you work on a computer?		**Hours per day**	

Social History	
What type of recreational drugs do you use?	
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	

Family History	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Glaucoma	
Cataracts	

Family History	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Macular Degeneration	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	
Heart Disease	
Hypertension	
High Cholesterol	
Kidney Disease	
Or please check:	[ ] I am adopted and my family history is unknown
Other	

Allergies- IF YOU HAVE NO ALLERGIES, PLEASE WRITE NONE			
Allergy	**Onset Date**	**Reaction**	**Severity**

Contact Lens History					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended)	

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak to our HIPAA Compliance Officer in person or by phone at 1441 E. Ocean Blvd, Stuart, Florida or 772-286-0007.

Signature below is acknowledgment that you have been shown a copy of the HIPAA Notice Of Privacy Practices. (Updated September 2013)

_____

Signature

_____

Print Name

_____

Date

WE WILL PROVIDE A WRITTEN COPY OF THIS NOTICE AT YOUR REQUEST.

Treasure Coast Eye Specialists

Richard Seith, MD

Carrie Palmer, MD

Christopher Frey, OD

Refraction Consent Form

Our office fee for refraction is $50 for all patients. This fee is collected in addition to any co-payment at time of visit.

A refraction is a diagnostic test used by your doctor to determine the cause of decreased visual acuity. It is done routinely to diagnose the need for a change in prescriptive eye wear, to determine the need for surgery (such as cataract), and to rule out eye diseases as the cause of diminished vision. This test is performed by placing various lenses in front of your eyes to see if your vision can be improved.

This procedure is part of your complete eye exam and it is not covered by Medicare, HMO's or any other insurance. It is an out-of-pocket expense for which you are obligated at the conclusion of your visit. Any questions or concerns should be directed to your insurance company.

ACKNOWLEDGEMENT

I, _____ have read the above information and understand that the refraction is a **non-covered service**. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee.

_____ _____

Patient Signature (OR Parent of minor) **Date**

Patient Consent and Authorization for Treatment

Date_____

I hereby agree to physical examination, treatment and services to be provided to me by Treasure Coast Eye Specialists.

I hereby authorize any physician, hospital, clinic or other provider of medical services and treatment to me release full details of my medical history and treatment to Treasure Coast Eye Specialists.

I hereby authorize Treasure Coast Eye Specialists to release any information acquired in the course of my examination or treatment when such information is requested for coordination of medical care, payment, workman's compensation, utilization review or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to Treasure Coast Eye Specialists.

I hereby authorize Treasure Coast Eye Specialists to release specifically information regarding a positive HIV/ AIDS status, mental illness information, and information related to drug and alcohol dependency to other providers, practices, and hospitals that we may refer you to in accordance with a coordination of medical care.

I hereby authorize payment to be paid directly to Treasure Coast Eye Specialists for all services rendered to me by Treasure Coast Eye Specialists and for which services are covered benefits under my insurance plan(s), including Medicare and Medicaid.

I understand that Treasure Coast Eye Specialists will file insurance claims with my insurance carrier(s) as a courtesy. However, I acknowledge and agree that in consideration of the services provided, I will pay any charges which are not paid by my insurance carrier(s) unless there is a specific written agreement between Treasure Coast Eye Specialists and the payer stating differently or it is restricted by state or federal regulations.

I understand that if my account becomes delinquent and past due, my account will be assigned to a collection agency. I agree to pay all costs of collections including interest, court costs, sheriff fees, attorney fees, and collection fees as may be necessary. In addition to the above, up to a 50% collection cost will be added to outstanding balance upon assignment to the collection agency.

_____ _____

Patient Signature Date

_____ _____ _____

Guardian Signature Relationship Date