FLORIDA RETINA AND VITREOUS CENTER, P.A. - ACCOUNT INFORMATION (Please Print)

DATE______________________ MEDICAL RECORD# _____________________ DR.'S NAME: Robert Kraut

NAME____
LAST *FIRST* *MI*

SEX______ BIRTHDATE__________________ AGE_______ PATIENT'S SOC. SEC.#______________________________

HOME PHONE (______)___________CELL #(____)_________________ WORK # (___)__________
AREA CODE *AREA CODE* *AREA CODE*

ADDRESS____
STREET *APT#* *CITY* *STATE* *ZIP*

EMPLOYER____

ADDRESS____
STREET *APT#* *CITY* *STATE* *ZIP*

REFERRED BY:

DR.____ CITY_______________________ PHONE ____________________

GENERAL MEDICAL DOCTOR:

NAME____ CITY______________________ PHONE _____________________

NAME AND ADDRESS OF RESPONSIBLE PARTY____

ARE YOU HERE FOR A SECOND OPINION? YES ❑ NO ❑

INSURANCE:

PRIMARY INSURANCE __________________________

POLICY HOLDER________________________________

POLICY HOLDER'S SOC. SEC. # __________________

ID #____

GROUP #______________________________________

ADDRESS _____________________________________

____

SECONDARY INSURANCE___________________________

POLICY HOLDER___________________________________

POLICY HOLDER'S SOC. SEC. #______________________

ID #____

GROUP #____

ADDRESS ____

____

WHAT RELATIONSHIP ARE YOU TO THE POLICY HOLDER? ____

EMERGENCY CONTACT: (OTHER THAN HOME TELEPHONE NUMBER)

NAME______________________________ PHONE# ________________________ RELATIONSHIP___________________

RECOMMENDED BY:

FRIEND/RELATIVE: NAME_______________________ ADDRESS____

OTHER: TELEVISION ❑ RADIO ❑ NEWSPAPER ❑ SEMINAR ❑

★★

LIFETIME INSURANCE AUTHORIZATION:

MEDICARE

I request that payment of authorized medicare and supplement insurance benefits be made either to me or on my behalf for any service furnished me by FLORIDA RETINA & VITREOUS CENTER, P.A.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

SIGNED____ **DATE**_________________

OTHER INSURANCE

I authorize the release of any medical information necessary to process this claim and related claims and assign insurance benefits directly to FLORIDA RETINA & VITREOUS CENTER, P.A., the amount due for medical expenses rendered at FLORIDA RETINA & VITREOUS CENTER, P.A. under the terms of my health insurance company.

I agree that any balance not covered by my insurance will be payable by me and photocopies of this form will be valid as the original.

SIGNED____ **DATE**_________________ **OVER**

PLEASE BRING THIS FORM WITH YOU THE DAY OF YOUR APPOINTMENT

MEDICAL/ SOCIAL HISTORY

DATE______________________ NAME:_______________________________

WHAT IS YOUR MARITAL STATUS? ❑Single ❑Married ❑Divorced ❑Widowed MED.RECORD#______________

PLEASE CHECK "YES" OR "NO" FOR THE FOLLOWING

Have you ever smoked? ❑ Yes ❑ No How long?_____________________ When did you quit? ______________

Alcohol ❑ Yes ❑ No Social Drug Use ❑ Yes ❑ No Caffeine use ❑Yes ❑No

1. Diabetes ❑ Yes ❑ No How long?	Medication
2. High Blood Pressure ❑ Yes ❑ No How long?	Medication
3. Heart Disease ❑ Yes ❑ No How long?	Medication
4. Cancer ❑ Yes ❑ No How long?	Medication
5. Arthritis ❑ Yes ❑ No How long?	Medication
6. Lung Disease ❑ Yes ❑ No How long?	Medication
7. Glaucoma ❑ Yes ❑ No How long? Surgery ❑Yes ❑No Which Eye? When?	Medication
8. Cataracts ❑ Yes ❑ No How long? Surgery ❑Yes ❑No When? Intraocular lens implant	Medication
9. Wear contacts How long?	❑Hard ❑Soft ❑Extended Wear
10. Take birth control pills ❑ Yes ❑ No How long?	Medication
11. Have a Lazy Eye (Amblyopia) ❑ Yes ❑ No How long?	Which Eye?

Is there a family history of any of the above diseases? ❑ Yes ❑No Which one(s)?____

List any other medical conditions you have ____

What other medicines do you take?____

What MEDICINES are you ALLERGIC to? ❑ Penicillin ❑ Sulfa ❑ Steroids ❑ Aspirin

❑ Other (list all)____

Are you ALLERGIC to EYE DROPS? ❑Yes ❑No Is Yes, please list ____

Have you ever had an eye examination?___________ ❑Ophthalmologist ❑Optometrist ❑ Other Date of last exam?______________

Name/Address of examiner__________________________ When was your last change in eyeglasses?___________________________

Do you use eye drops?______ If Yes, please list____

Have you ever been hit in the eye?_____________ _______ When?__________________ Which Eye?_________________________

What eye surgery have you had?__________________________ Are you or have you ever been cross-eyed? ______________________

WHAT IS THE MAIN PROBLEM YOU ARE CURRENTLY HAVING WITH YOUR EYES?_____________________________________

____

____ Occupation ______________________

I understand that many examinations will require dilation of the pupil of the eyes which may make my driving vision blurry and light sensitive and my transportation is my responsibility.

Signature____

INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATION TO CHILDREN

I give my permission for eye medication to be administered to my son/daughter. I understand that these medications are for the purpose of his/her diagnosis and treatment.

I realize in that in the course of this diagnosis and treatment my child may need to be restrained by being held during the administration of drops or examination. In that event, I understand that I am responsible for the restraint and holding of my child.

Signature____