FLORIDA RETINA & VITREOUS CENTER, P.A.
Robert J. Kraut, M.D.

ACCOUNT INFORMATION (Please Print)

PATIENTNAME:_____DATE:_____
LAST FIRST MI

DATE OF BIRTH:_____ AGE:_____ SEX:_____ SOCIAL SECURITY #:_____

RACE:_____ PREFERRED LANGUAGE:_____ ETHNICITY: ☐HISPANIC/LATINO ☐NON-HISPANIC/LATINO

PRIMARY PHONE:_____ SECONDARY PHONE:_____

ADDRESS:_____
STREET APT# CITY STATE ZIP

REFERRING DR:_____PRIMARY CARE PHYSICIAN:_____

EMERGENCY CONTACT:_____
NAME PHONE RELATIONSHIP

IS PATIENT IN A SKILLED NURSING FACILITY OR REHAB CENTER? ☐YES ☐NO IF YES PROVIDE FACILITY:

_____
NAME ADDRESS PHONE

PHARMACY:_____
NAME PHONE NUMBER

_____
ADDRESS CITY STATE ZIP

_____There will be a $50 cancellation fee for appointments that are NOT cancelled within 24 hours notice
initial

PRIMARY INSURANCE:_____ID# (if card not provided)_____

POLICY HOLDER(if not patient):_____
NAME DOB SS# RELATION

SECONDARY INSURANCE:_____ID# (if card not provided)_____

POLICY HOLDER (if not patient):_____
NAME DOB SS# RELATION

LIFETIME MEDICARE/HEALTH INSURANCE AUTHORIZATION: I request that payment of authorized Medicare and insurance benefits be made on my behalf for services furnished to me by Florida Retina and Vitreous Center, P.A. I authorize any holder of medical or other information about me to be released to the healthcare financing administration and/or its agents information needed to determine these benefits for related services. I request that payment of authorized insurance/Medicare benefits be made on my behalf to Florida Retina and Vitreous Center, P.A. for any services for me by a physician or supplier. I authorize any holder of medical information about me whether medical or otherwise to be released to any of my insurance companies/third party payers any information needed to determine these benefits payable for related services. I hereby authorize payment directly to Florida Retina and Vitreous Center, P.A. of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denied as a result of preexisting conditions. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare assignment of benefits apply. I further authorize Florida Retina and Vitreous Center, P.A. to fax/electronically transmit the results of my evaluations to my referring physician if appropriate.

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to undersigned physician or supplier for service described

FINANCIAL POLICIES: I am responsible for confirming that Dr. Kraut is “in network” with my insurance plan and also for obtaining any required referral and/or authorization numbers. If Dr. Kraut is out of network, and/or necessary referrals/authorizations are not obtained I will be responsible for all service rendered. Any non-covered services will be my responsibility upon notice from insurance carriers. Copayment, coinsurance and deductibles are required to be paid at the time services are rendered. Self pay patients are required to pay at time of service.

SIGNATURE:_____ _____
PATIENT/LEGAL GUARDIAN **DATE**

MEDICAL / SOCIAL HISTORY (Please Print)

PATIENT NAME:_____ DOB:_____ DATE:_____

Have you ever smoked ☐Yes ☐No How long? Qty per day Date you quit

Alcohol ☐Yes ☐No Social drug use ☐Yes ☐No Caffeine ☐Yes ☐No

Do you have any know allergies? ☐Yes ☐No If YES please list:_____

CURRENT PRESCRIPTIONS & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

DRUG NAME	DOSAGE	FREQUENCY

EYE HISTORY	Check if YES
Do you wear glasses/contacts	
Amblyopia (lazy eye)	
Glaucoma	
Macular degeneration	
Retinal tear/detachment	
Cataract	
Strabismus (crossed eyed)	
LASIK/RK	
Eye trauma	

EYE - LIST ANY LASERS, SURGERIES, INJECTIONS:_____

_____

_____

WHAT IS THE MAIN COMPLAINT YOU ARE HAVING WITH YOUR EYE/EYES:_____

_____

_____

FAMILY HISTORY (EYE)	Check if YES	RELATIONSHIP
Macular degeneration		
Glaucoma		
Retinal tear/detachment		

MEDICAL HISTORY AND REVIEW OF SYSTEMS		Check if YES
General/constitutional	Fever, weight loss	
Head, ear, nose, throat	Headache, hearing loss, sinus	
Respiratory	Asthma, COPD	
Cardiovascular	Heart disease, high blood pressure, arrhythmia	
Gastrointestinal	Diarrhea, vomiting	
Genitourinary	Kidney diseases	
Metabolic/endocrine	Diabetes, thyroid disorders	
Neurological	Seizures, strokes	
Psychiatric	Depression, anxiety	
Integumentary	Rash, skin disorders	
Musculoskeletal	Arthritis	
Hematologic	Bleeding/clotting disorders, leukemia	
Immunologic	Immune disorders	

LIST ANY SURGERIES AND DATE:_____

_____

_____

_____

LIST ANY MEDICAL CONDITIONS YOU HAVE:_____

_____

_____

_____

_____

FAMILY HISTORY	Check if YES	RELATIONSHIP
Cancer		
Diabetes		
Hypertension		
Heart Disease		

I understand that my eyes may be dilated which may cause blurry vision, light sensitivity, and impaired vision while driving.

Signature of Patient/Guardian:_____

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PATIENT NOTICE OF PRIVACY PRACTICES (Please Print)

PATIENT NAME:_____

Florida Retina and Vitreous Center's Notice of Privacy Practices is available at check in

I have been given the opportunity to read the Florida Retina and Vitreous Center's Notice of Privacy Practices Policy concerning how my personal information may be used. I give my permission to use my personal information in accordance with this policy. This signature sheet will remain in the patient's chart as a record of acceptance. I authorize the release of protected health information to my insurance company only to the extent necessary to obtain payment for services rendered.

AUTHORIZATION TO RELEASE INFORMATION

To protect your privacy and in conjunction with our policy please provide us with the following information and authorizations. If you want our office to discuss your treatment and billing information with a spouse, child, family member, care giver, etc., please list their names below. Please notify us in writing if there are ever any changes to the list below:

_____	_____
Name	Phone
_____	_____
Name	Phone
_____	_____
Name	Phone

SIGNATURE:_____ **DATE:**_____

PRINTED NAME:_____ **Date of Birth:**_____

NEXT MD PATIENT PORTAL ENROLLMENT
TO RECEIVE MEDICAL/FINANCIAL INFORMATION ONLINE (Please Print)

NEXT MD gives you the opportunity to log in electronically to receive medical information through a convenient, safe, and secure environment. You are enrolled in NEXT MD using your email.

After enrolling you will receive an email from NEXT MD with further instructions to complete enrollment. This is a complimentary service provided by Florida Retina and Vitreous Center.

Would you like to enroll in NEXT MD? ☐ YES ☐ NO If YES complete the following:

EMAIL ADDRESS: _____ **DATE:**_____

SIGNATURE:_____ **PRINTED NAME:**_____