Oviedo Eye Care
171 S Central Ave
Oviedo, FL 32765

Port St John Eye Care
3720 Curtis Blvd #106
Port St John, FL 32927

PATIENT INFORMATION FORM

Patient's Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____

Social Security #: _____ Driver's License #: _____

Spouse's Name: _____ Spouse's Phone Number: _____

Parent/Guardian (if minor): _____

Person responsible for payment:_____

Insurance Company: _____

How did you hear about us? _____

MEDICAL HISTORY

Do you have problems with any of the following areas?

Cardiovascular	**SELF**	**FAMILY (Parents or Siblings)**
-Heart Disease	_____	_____
-High Blood Pressure	_____	_____
-Lung Disease	_____	_____
Endocrine		
-Diabetes type I	_____	_____
type II	_____	_____
-Thyroid Disorder	_____	_____
Urinary		
-Kidney Disease	_____	_____
-Bladder Disease	_____	_____
Musculo-skeletal		
-Arthritis	_____	_____
-Other	_____	_____
Gastro-Intestinal		
-Crohn's Disease	_____	_____

OVER…

MEDICAL HISTORY (Cont.)

	SELF	FAMILY
-Ulcerative Colitis	_____	_____
Immune Disease		
-Cancer	_____	_____
-other	_____	_____
Blood Disorders	_____	_____
Ear, Nose, Throat	_____	_____
Neurological/Psychiatric		
-Stroke	_____	_____
-Epilepsy	_____	_____

Current Medications (including eye drops): _____

_____

_____

_____

Do you have any allergies? **Y/N** If yes, to what? _____

Do you use cigarettes/tobacco? **Y/N** If yes, amount per day? _____

Do you use alcohol? **Y/N** If yes, drinks per day? _____

Do you use social drugs? **Y/N**

OCULAR HISTORY

	SELF	FAMILY
Glaucoma	_____	_____
Cataracts	_____	_____
Macular Degeneration	_____	_____
Retinal Detachment	_____	_____
Eye Surgeries	_____	_____
Eyestrain/Headaches	_____	_____

When was your last eye exam? _____

Do you wear glasses? **Yes** **No** If so, how long? _____

Do you wear contact lenses? **Yes** **No** If so, hard/soft and how long? _____

Are you interested in trying contact lenses? **Yes** **No**

Name of Primary Care Physician? _____

Robert S. Webster, O.D.
Oviedo Eye Care
(407) 365 – 7475

Oviedo and Port St. John Eye Care

Chi C. Tran, O.D.
Port St. John Eye Care
(321) 639 – 0910

Financial Statement and Authorizations

Please Print Name: _____ Date: _____

I authorize payment of medical benefits to the attending optometrist for services, however I understand that I am fully responsible for all professional fees and expenses incurred. If my health insurance carrier does not pay a portion of my bill, I agree to immediately pay the entire remaining balance.

It is the policy of this practice that full payment (including co-pays, deductibles and patient percentages) is due at the time services are rendered. We are happy to accept your payment by cash, check, Visa, MasterCard, Discover, American Express and Debit Card. We will submit claims to those insurance companies with which we have a contract, however it is the sole responsibility of the insured to know the type of insurance and coverage. All patients will be given receipts that will be sufficient to submit to an insurance company for reimbursement. Any balances that are over 90 days past due will have the credit reporting agencies notified and be turned over to a collections agency unless previous arrangements have been made.

To all Medicare Patients: We are happy to continue to participate as Medicare providers. We will bill Medicare, as well as your secondary insurance. If payment is not received from your secondary (or is denied for any reason) within 45 days, you will be notified and will be required to pay our office the balance due. You must file for reimbursement through your secondary insurance to receive payment for the balance you paid our office.

Remember, you and/or your employer pay the insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claim.

Signature: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize Dr. Webster, Dr. Tran and their staff to share my personal information, such as appointments, pick up and/or drop off of glasses or contacts, and any other details in relation to my eye care, with the following person(s).

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization **IN WRITING** at any time. Unless revoked, this authorization will not expire.

Signature: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

At all times, our Privacy Practices (HIPAA) are posted in the office. I acknowledge that I have been made aware of Robert S. Webster, O.D.'s, Notice of Privacy Practices and are aware of the fact that I can receive a free copy upon request.

Signature: _____

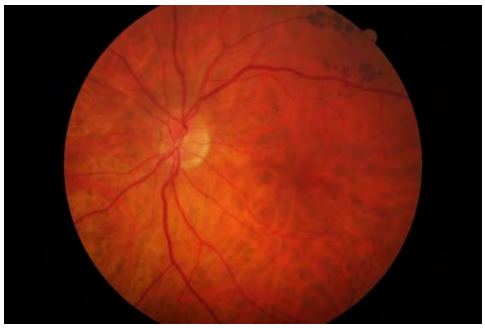
Oviedo & Port St. John EYE CARE

Robert S. Webster, OD

We are committed to providing quality eye care to our patients by using the most advanced equipment and techniques. As part of this commitment, we have two screening tests that are in addition to your comprehensive eye exam.

Retinal Imaging

As an ongoing commitment for providing quality care, Dr Webster and staff are pleased to inform you of our latest addition to the office that will help ensure a more complete eye exam. This optional test is called Digital Retinal Imaging where remarkably clear and enlarged photograph images are taken of the back of your eyes (the retina, macula, optic nerve, and blood vessels). Together, you and the Doctor will review the images of the inside of your own eyes and discuss the results. Retinal photography is a necessity in a variety of ophthalmic conditions like glaucoma, diabetic retinopathy and macular degeneration. By monitoring any changes to your eyes, immediate treatment or a referral to another health care provider can be offered.



Visual Field

In addition to our retinal imaging, we also offer a visual field screening. Our Visual Field Analyzer is a highly sophisticated, computerized machine that checks for areas of reduced vision in the central (straight ahead) and peripheral (side vision) areas. Visual field testing is important in the early detection of diseases and conditions like Glaucoma, Retinal Detachment, Brain Tumors, Optic Nerve Disease, Macular Degeneration and Diabetes. **As medical professionals, we strongly recommend that all of our patients aged 13 and over take this evaluation once a year, especially those that have a family history of poor ocular health or personal history of unusual headaches or vision problems.** Unfortunately, an individual does not notice most visual field defects until the very late stages.

Early detection is so important because treatment at an early stage can delay progression and reduce the severity of eye diseases and other health conditions. For a future of healthy sight, retinal imaging is recommended every two years as part of your regular eye test and the visual field screening yearly. **Each test requires an additional five minutes of your time.**

The **Visual Field Screening** and **Retinal Imaging Screening** is NOT covered by routine vision insurance, but is available for a nominal fee of $15 for the Visual Field Screening, $35 for the Retinal Imaging Screening, or as a package together for $40 for both tests.

Would you like the Visual Field Screening? **Yes** _____ **No** _____

Would you like the Retinal Imaging Screening? **Yes** _____ **No** _____

Name (please print): _____

Signature: _____ Date: _____

Oviedo and Port St. John Eye Care Lifestyle Questionnaire

Note to patients: This questionnaire was created to assist your eye care professional in helping you choose the eye wear best suited to your particular needs and lifestyle concerns. Please take a moment to answer all of the questions that apply to you.

1. **What do you like about your current pair of glasses?**

2. **What do you dislike about your current pair of glasses?**

3. **Do your home maintenance or work activities include:** (check all that apply)
   a) Gardening/Landscaping
   b) Woodworking/sawing/wood chipping
   c) Use of power tools
   d) Yard work (mowing, trimming, etc)
   e) Metal work/Welding
   f) Auto repair
   g) Painting
   h) Use of chemicals/caustic materials
   i) Other

4. What are your favorite hobbies/recreational activities: (check all that apply)
   a) Bicycling
   b) Boating/Fishing
   c) Bowling
   d) Card games/Bingo/Board games
   e) Carpentry/Woodworking
   f) Ceramics
   g) Computer games
   h) Cooking
   i) Crochet/Needlework/Sewing/Knitting
   j) Gardening
   k) Golf
   l) Metal work/Welding
   m) Hiking/Camping
   n) Hunting
   o) Photography
   p) Team Sports (including racquetball and tennis)
   q) Running/Jogging
   r) Motorcycles
   s) Skiing
   t) Snorkeling/Swimming
   u) Surfing
   v) Water Skiing
   w) Other

4. **Are you bothered by glare from any of the following:**
   a) Night driving/glare from headlights
   b) Sunshine/UV exposure
   c) Fluorescent lights
   d) Haze
   e) Computer screens
   f) Other

5. Does your work entail unusual visual demands due to any of the following:

a) Distance work
b) Up close work
c) Position
d) Natural or artificial lighting
e) Abrupt changes in light levels
f) Other

6. Do you wear contact lenses?

Yes
No

7. Do you currently use more than one pair of glasses?

Yes
No

If so, state whether you use your second pair of glasses for a particular reason: (check all that apply)

a. Hobby/recreational activity
b. Sports/protective eye wear
c. When driving a car
d. Prescription sunglasses
e. Occupational eye wear
f. Reading Glasses
g. evening/comfort wear
h. Fashion Wear
i. Other

8. Please circle the most appropriate description below:

1. I use a computer	Frequently	Occasionally	Never
2. I spent time outdoors	Frequently	Occasionally	Never
3. I need to see clearly up close	Frequently	Occasionally	Never
4. I drive at night	Frequently	Occasionally	Never
5. I like to read in bed	Frequently	Occasionally	Never
6. Technology is important to me	Frequently	Occasionally	Never

9. What is potentially the most hazardous activity you participate in on a regular basis, either at work or outside the workplace?

Thank you for filling out our questionnaire. Your answers will better help our eye care professionals assist you in choosing the right eye wear for your needs.