PATIENT REGISTRATION AND CONSENT

Patient Name (Last, First, Middle Initial)					DOB / /
Address		City		State	Zip
Home Phone ( )	Cell Phone ( )		Email (required for patient portal access)		
Social Security #	☐ M ☐ F ☐ Other	Ethnicity	Race		Preferred Language

Emergency Contact			
Name		Relationship	Phone
Primary Insurance			
Name	ID#	Subscriber Name	DOB
Secondary Insurance			
Name	ID#	Subscriber Name	DOB
All non covered insurance items are patient responsibility			
Preferred Pharmacy			
Name		Address	Phone
Primary Care Physician (PCP)			
Name		Address	Phone
Referring Doctor (Other than PCP)			
Name		Address	Phone

Patient Consent

- I have been provided a copy of the Notice of Patient Privacy Practices that provides a more complete description of Protected Health Information uses and disclosures.
- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Perich Eye Center and its associated providers, clinicians and other personnel. I understand that no guarantee has been or can be made as to the results.
- I consent to the use and disclosure of my/the patient's Protected Health Information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Notice of Patient Privacy Practices.
- I authorize payment of medical benefits directly to Perich Eye Center or their designee for services rendered.
- I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
- If you receive a prescription from any Perich Eye Center location for eyeglasses/contacts and purchase online, **we have a NO REFUND POLICY** on all contacts, frames, eyeglass lenses, and complete pair of glasses.

Patient Name (print) ______________________________ Date _____ / _____ / _____

Patient / Authorized Person Signature ______________________________

PATIENT MEDICAL HISTORY

Please select any of the following medical conditions that you currently have:

☐ ANXIETY
☐ DEPRESSION
☐ PSYCHIATRIC DISORDER
☐ CLAUSTROPHOBIA
☐ MEMORY LOSS
☐ ALZHEIMER'S
☐ MIGRAINES
☐ SEIZURES
☐ STROKE
☐ HEARING LOSS

☐ ARTHRITIS
☐ ASTHMA
☐ COPD
☐ IRREGULAR HEARTBEAT
☐ CORONARY ARTERY DISEASE
☐ HIGH BLOOD PRESSURE
☐ HEART ATTACK
☐ HIGH CHOLESTEROL
☐ DIABETES
☐ GERD

☐ END STAGE RENAL DISEASE
☐ HEPATITS
☐ HIV/AIDS
☐ MRSA
☐ HYPERTHYROIDISM
☐ HYPOTHYROIDISM
☐ ENLARGED PROSTATE
☐ CANCER; Which Kind: ____________________
☐ RADIATION / CHEMO

☐ OTHER ____________________

Have you had any surgeries within the past 4 years? If yes, please list: ____________________

____

____

____

OCULAR HISTORY / OR CURRENTLY EXPERIENCING

☐ CATARACTS: R Eye L Eye
☐ GLAUCOMA: R Eye L Eye
☐ MACULAR DEGENERATION: R Eye L Eye
☐ RETINAL DETACHMENT R Eye L Eye
☐ VITREOUS FLOATERS R Eye L Eye
☐ FLASHES OF LIGHT: R Eye L Eye

☐ BLEPHARITIS: R Eye L Eye
☐ OPHTHALMIC MIGRAINE R Eye L Eye
☐ DRY EYE SYNDROME
☐ GLASSES Prism
☐ CONTACTS: Hard Soft
☐ OTHER ____________________

OCULAR PROCEDURES / SURGERIES

☐ CATARACT SURGERY: R Eye L Eye
☐ YAG CAPSULOTOMY R Eye L Eye
☐ LASIK SURGERY: R Eye L Eye
☐ RETINAL DETACHMENT: R Eye L Eye
☐ RETINAL LASER: R Eye L Eye
☐ CORNEAL TRANSPLANT: R Eye L Eye

☐ GLAUCOMA SURGERY: R Eye L Eye
☐ GLAUCOMA LASER: R Eye L Eye
☐ INTRAVITREAL INJECTIONS: R Eye L Eye
☐ EYE MUSCLE SURGERY: R Eye L Eye
☐ LID SURGERY: R Eye L Eye
☐ PUNCTAL PLUGS: R Eye L Eye

Please list below all of your prescribed medications, ocular medications and over the counter medications you take (including vitamins); or if you have a list we will make a copy

NAME OF MEDICATION	DOSAGE	FREQUENCY

Do you have a **SENSITIVITY** to **LATEX?**
YES NO

Are you **SENSITIVE** to **ADHESIVE TAPE?**
YES NO

LIST OF ALLERGIES: ______________________________

____

____

____

____

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO ☐ FORMER How much per day? ____________

Do you drink alcohol? ☐ YES ☐ NO ☐ FORMER How much per day? ____________

FAMILY HISTORY

Please indicate (✓) which family members have / had the following diseases:

Condition	Father	Mother	Brother	Sister
Blindness				
Cancer				
Diabetes				
Glaucoma				
High Blood Pressure				
Macular Degeneration				
Stroke				
Thyroid Disease				

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Name: ______________________________________ Date of Birth: _____ / _____ / _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse ____
- ☐ Child(ren) ____
- ☐ Other ____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell phone: ________________________

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ ____

The best time to reach me is (day) ________________________ between (time) ____________

Signature: ____ Date: _____ / _____ / _____

Witness: ____ Date: _____ / _____ / _____

DILATION CONSENT & NOTIFICATION FORM

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate pupils of your eyes. This will require placing drops in your eyes that will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision. In most cases the distance vision will be minimally affected. In some instances you may experience blurred distance vision following your exam, our office recommends that you have someone to assist you with diving after your appointment. As a precaution, you were advised, when you scheduled your appointment, you had the option to bring a driver with you. The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may wish to omit this procedure. **Please indicate your preference below:**

__________ **I have read and understood the above stated information and I choose to be dilated.**

__________ **I do not wish to be dilated and I understood that certain pathologies may not be detected as a result.**

Patient's Name: ____

Patient's Signature: ____

Date: ______ / ______ / ______

Cancellation / No Show Policy
For Doctor Appointments

Cancellation / No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment and appointments are in high demand.
Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company and will be payable upon your next visit.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 20 minutes past their scheduled time we may have to reschedule the appointment.

____

Patient Name (Print)

____

Patient Signature

______ / ______ / ______ Patient Account # ____________________
Date (Office Use Only)

*Perich Eye Centers of New Port Richey * Spring Hill * Tampa*
*The Eye Institutes of The Villages * Wesley Chapel * Zephyrhills*