Dilated Fundus Exam

The Florida Board of Optometry has established that a comprehensive eye exam for a new patient includes a Dilated Fundus Exam. This procedure involves putting drops in each eye that will enlarge the pupils. Dr. Pearson will then examine the internal structures of the eyes to ensure proper health. These drops cause light sensitivity and blurred vision for 2-4 hours on average. There is no additional charge for this service.

Please Choose One: ◯YES ◯NO

3D-OCT Retinal Imaging & Humphrey FDT Analyzer

Unfortunately, routine eye exams cannot detect many eye diseases such as Glaucoma, Multiple Sclerosis and Brain Tumors, in their early stages. We recommend that all patients receive an evaluation using the FDT Analyzer as well as Retinal lmaging. It is recommended every year for those patients with a history of or at risk of High Blood Pressure, Headaches, Migraines, Floater(s) or High Spectacle Prescriptions. Please understand that while these tests are optional for most, they represent preventative health for others. They may be required to "rule out" certain eye related diseases.

Our fee for these tests is $40. These are considered screenings and are not subject to insurance reimbursement.

Please Choose One: ◯YES ◯NO

Email Address: _____

Can we contact you via email: ◯YES ◯NO

Can we contact you via text: ◯YES ◯NO

NOTE: All patient information is kept strictly confidential and will be used solely for the purpose of providing a higher level of patient care and communication.

_____ _____

Signature Date

PATIENT HEALTH HISTORY

Patient First Name: _____ Last Name: _____ MI:___ DOB:_____ Gender: ◯M ◯F

Home Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Daytime/Work Phone:_____ Cell Phone: _____

Email Address: _____ Social Security: _____

Employer: _____ Occupation: _____ Referred by: _____

Preferred Language:_____ Would preferred to be contacted via:_____ Texting: ◯ Yes ◯ No

Race/Ethnicity: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ White

◯ Native American or other Pacific Islander ◯ Hispanic ◯ Not Hispanic or Latino ◯ Declined to specify

INSURANCE INFORMATION: (Please fill out)

Health Insurance:_____ Member ID:_____ Member Name:_____

Member DOB:_____ Member SSN:_____ Relationship to Patient:_____

Vision Insurance:_____Member ID:_____ Member Name:_____

Member DOB:_____ Member SSN:_____ Relationship to Patient:_____

MEDICAL/FAMILY HISTORY:

Primary Care Physician:_____ Date Last Seen by PCP:_____

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

_____

_____

Please list all allergies (medications as well as other allergens): _____

_____

_____

List all major surgeries and medical conditions (Eye Surgery included): _____

_____

_____

Do you currently wear: ◯ Contacts ◯ Eye Glasses

Please indicate if any of the conditions apply to you or a family member (blood relatives only)**:**

DISEASE/CONDITION	YOURSELF	RELATIVE	LIST FAMILY MEMBER (Please indicate Relationship & Maternal/Paternal)
Cataract	◯	◯	_____
Eye Turn	◯	◯	_____
Glaucoma	◯	◯	_____
Macular Degeneration	◯	◯	_____
Retinal Detachment	◯	◯	_____
Blindness	◯	◯	_____
Other:_____			

Review of Systems (Please indicate below If you have or ever had problems with the following conditions):

Allergic/Immunologic
◯ None
◯ Lupus (SLE)
◯ Rheumatoid Arthritis
◯ Environmental Allergies
◯ Lyme Disease
◯ Other

Cardiovascular
◯ None
◯ High Blood Pressure
◯ Heart Disease
◯ Stroke
◯ Vascular Disease
◯ High Cholesterol

Hematologic/Lymphatic
◯ None
◯ Anemia
◯ Leukemia
◯ Bleeding Disorder
◯ Other

Ear, Nose and Throat
◯ None
◯ Sinusitis
◯ Upper Respiratory
◯ Tract Infection
◯ Other

Endocrine/Glands
◯ None
◯ Diabetes
◯ Hormone Dysfunction
◯ Thyroid Dysfunction
◯ Other

Neurological
◯ None
◯ Multiple Sclerosis
◯ Epilepsy
◯ Tremors
◯ Other

Gastrointestinal
◯ None
◯ Crohn's Disease
◯ Colitis
◯ Acid Reflux/Ulcer
◯ Other

Respiratory
◯ None
◯ Asthma
◯ Bronchitis
◯ Emphysema
◯ Other

General Health
◯ None
◯ Weight loss/gain
◯ Fever
◯ Fatigue
◯ Trauma

Skin
◯ None
◯ Eczema
◯ Rosacea
◯ Psoriasis
◯ Other

Muscle/Skeletal
◯ None
◯ Arthritis
◯ Fibromyalgia
◯ Ankylosing Spondylitis
◯ Other

Psychiatric
◯ None
◯ Depression
◯ Bi-Polar
◯ Schizophrenia
◯ Other

Genital/Urinary
◯ None
◯ Urinary Tract Infection
◯ HIV Positive
◯ Herpes/Chlamydia
◯ Other

Social
Tobacco Use:_____
◯ Current Smoker
◯ Previous Smoker
Non-Prescription Drugs
_____
Alcohol Consumption
_____x drinks per
◯ day ◯ month ◯ yr

Weight. _____

Height. _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials :_____

SABAL EYE CARE
DR. CHRISTOPHER PEARSON, O.D.
105 E. Lake Brantley Drive, Longwood, Florida 32779 Tel. 407-869-1733

PATIENT ACKNOWLEDGMENT

NOTICE OF PRIVACY POLICY

Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge that you have received a copy of the Notice of Privacy Practices of Sabal Eye Care.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of patient Relationship

CONSENT OF DISCLOSURE

FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

During the course of providing service to you, we create, receive and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations, that includes:

- The use and disclosure of your health information for treatment purposes. Not only includes care and services provided here, but may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but not limited to, providing this information to your insurance company, third party, billing agent, or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies will have access to your health information.
- The payment of medical insurance benefits to Sabal Eye Care or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

ADVANCE BENEFITS NOTICE

MEDICARE AND OTHER HEALTH INSURANCE COMPANIES MAY OR MAY NOT COVER REFRACTION. IF THE CLAIM COMES BACK FROM YOUR INSURANCE COMPANY DENIED, YOU WILL BE RESPONSIBLE FOR OUR FEE OF S55 TO COVER THE COST OF REFRACTION.

By signing below, you acknowledge that you have read and understand the above information and voluntarily consent to the statements herein.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of patient Relationship