Patient Demographics

Last Name _____ First Name _____ Middle Initial _____

Address (Local) _____ City _____, State _____ Zip Code _____

Address (Northern) _____ City _____, State _____ Zip Code _____

Phone Number (_____)_____ Phone Number (_____)_____ Social Security Number _____

Birthday _____ Sex _____ Marital Status _____ Spouse Name _____

Family Physician _____ Phone Number _____

Referred By _____ Preferred Pharmacy _____

Closest Relative Not Living With You _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Patient's Employer _____ Address _____ Phone Number _____

Primary Insurance _____ Secondary Insurance _____

NAME: _____ AGE:_____REF. BY/PCP: _____ DATE:_____

Please answer the following questions about your medical status and history:

(Use the back of the sheet if you need more room to answer any question)

1. Have you ever been treated for *any* medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   ☐ Yes ☐ No If YES, please explain_____
   _____
2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment?
   ☐ Yes ☐ No If YES, please explain_____
   _____
3. When was your last eye exam? _____
4. Have you ever had *any* surgery? (e.g. appendix, tonsil, knee, and eye surgeries)
   ☐ Yes ☐ No If YES, please explain_____
   _____
5. Do you take *any* medications?
   ☐ Yes ☐ No If YES, which medications? ☐ see list_____
   _____
6. Do you have any drug or food allergies?
   ☐ Yes ☐ No If YES, please explain._____
   _____

Review of Systems: Do you *currently* have any of the following problems?	Yes	No	If Yes, Please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat Problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart Problems (e.g. chest pain, irregular heartbeat)	☐	☐	_____
Respiratory Problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal Problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary Problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin Problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal Problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic Problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric Problems (e.g. depression, anxiety)	☐	☐	_____
Endocrine Problems (e.g. diabetes, thyroid)	☐	☐	_____
Allergic/Immunological (e.g. hayfever, lupus, HIV)	☐	☐	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, and macular degeneration) ☐ Yes ☐ No If YES, please explain: -_____
_____

Do you smoke? ☐ Yes ☐ No If YES, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If YES, how much? _____

If employed, how many hours per week do you work? _____

Neil B. Zusman M.D./ Daniel Solano D.O. _____

Harborside EYE SPECIALISTS

Patient Name: _____ Date: _____ DOB: _____

Medication (Rx, vitamin, herbal, etc)	Dosage (Ex: 80mg)	Frequency (ex: twice a day)	Route (ex: by mouth)

Are you a current smoker?

Yes ☐ No ☐

Have you been counseled on smoking cessation?

Yes ☐ No ☐

_____ _____

Physician's Signature Date

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye. The dilating drops are necessary to diagnose your condition.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make you much more sensitive to light. Because of this sensitivity, sunglasses should be worn when your eyes are dilated. Disposable sunshields are available at our check out desk. It is not possible for your ophthalmologist to predict how much your vision will be affected. After an examination, your ability to drive safely may be impaired due to the effect of the dilating drops on your vision. Therefore, you should not drive yourself, but make arrangements to be driven to and from your appointments.

I have read and completely understand the above information regarding dilating drops. I have been advised that I should not drive, or operate machinery, while my eyes are dilated because my vision, and thus my driving ability may be impaired. If I choose to drive or operate machinery despite this warning, I assume full responsibility (financial and otherwise) for the consequences resulting from this choice.

I agree that my doctor, Harborside Eye Specialists, and its employees, are released from all liability resulting from my driving or operating machinery while my eyes are dilated. I hereby authorize my doctor at Harborside Eye Specialists and/or such assistants may be designated by my doctor to administer dilating eye drops.

I understand that the use of dilating drops is necessary to diagnose and evaluate my condition. I hereby consent to the use of dilating drops at this time and all of my future visits.

_____ _____

Print Patient Name Date

_____

Patient Signature

_____ _____

Witness Date

INSURANCE AND PAYMENT AUTHORIZATION

AUTHORIZATION AND ASSIGNMENT - I assign payment to the physician/office at Harborside Eye Specialists for any medical benefits due to services rendered.

MEDICARE AUTHORIZATION - I request that payment of authorized Medicare benefits be made to me and/or the physician for any services furnished to me at or billed through this facility.

MEDIGAP AUTHORIZATION - If I have Medigap supplement insurance, I authorize payment to be made to me and/or the physician providing the services.

PAYMENT PLAN - Payment for copays, deductibles, and non-covered services such as **REFRACTIONS** (test for eyeglasses) are expected at the time of service. If you are unable to meet this obligation, please make arrangements with the office manager.

RETURNED CHECK FEES/Collection Agency - Should your check be returned by the bank, a $30.00 fee will be added to your account. I am directly and fully responsible for all charges for the services rendered to me, including balances remaining after insurance payments, if any. I understand that all co-payments, deductibles, and coinsurance are due at the time of service unless otherwise agreed upon. I also acknowledge that failure to make timely payments may result in the balance being sent to a collection agency.

I understand that it is my responsibility to notify (Clinic/Physician's name) of any changes in my insurance coverage, address, or contact information. Out of courtesy to our patients, we file with your insurance company. If your insurance company does not pay within 60 days, you will be responsible for the bill.

☐ **By signing this binding agreement, I acknowledge that I have read, understand, and agree to the terms set forth above.**

_____ _____

Guarantor Signature Date

Harborside
EYE SPECIALISTS

HIPAA CONSENT FORM

Health Insurance Portability and Accountability Act (HIPAA) Health Information Technology for Economic & Clinical Health (HITECH)

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Harborside Eye Specialists may use and disclose protected health information (from now on referred to as PHI) about me to carry out treatment, payment, and healthcare operations (hereinafter referred to as TPO). Please refer to Harborside Eye Specialist's Notice of Privacy Practices (hereinafter referred to as NPP) for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. Harborside Eye Specialists reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written notice to Harborside Eye Specialists Privacy Officer at P.O. Box 495658, Port Charlotte, FL 33949.

With my consent, Harborside Eye Specialists may call my home or other designated location and leave a message on my voicemail or mail to my home any items that assist the practice in carrying out TPO such as appointment reminders, Insurance Issues, and patient statements. Any call pertaining to my PHI, including laboratory results, prescriptions among others will be protected.

I have the right to request that Harborside Eye Specialists restrict how they use or disclose my PHI and my TPO. However, Harborside Eye Specialists is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Harborside Eye Specialists' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that Harborside Eye Specialists has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Harborside Eye Specialists may decline to provide treatment to me.

Other authorized person(s) to whom PHI may be disclose: _____

_____

Signature of Patient or Legal Guardian

_____ Date _____

Printed Name