

SUN CITY CATARACT CENTER AND EYE CLINIC

ACCOUNT NUMBER: _____

DATE: _____

PLEASE PRINT

PHONE: _____

PATIENT'S NAME: _____ CELL: _____

PATIENT'S ADDRESS: _____
street city state zip

SECOND OR SUMMER ADDRESS: _____
street city state zip

PATIENT'S AGE: _____ DATE OF BIRTH: _____ SOC. SEC. #: _____

MARITAL STATUS: ___ S ___ M ___ W ___ D SEX: F ___ M ___ SPOUSE'S NAME: _____

PERSON RESPONSIBLE FOR BILL: _____ SPOUSE'S/PARENT'S SOC. SEC. #: _____

EMPLOYER'S NAME AND ADDRESS: _____ PHONE: _____
OR FATHER'S (IF PATIENT IS A MINOR) EXT.: _____

SPOUSE'S EMPLOYER AND ADDRESS: _____ PHONE: _____
OR MOTHER'S (IF PATIENT IS A MINOR) EXT.: _____

REFERRED BY: _____ RELIGION: _____

MEDICAL HISTORY

DO YOU HAVE?	HOW LONG?	DO YOU HAVE?	HOW LONG?
YES ___ NO ___ HIGH BLOOD PRESSURE	_____	YES ___ NO ___ CANCER	_____
YES ___ NO ___ DIABETES	_____	YES ___ NO ___ EMPHYSEMA / ASTHMA	_____
YES ___ NO ___ HEART TROUBLE	_____	YES ___ NO ___ ARTHRITIS	_____
YES ___ NO ___ STROKE	_____	YES ___ NO ___ THYROID PROB.	_____
YES ___ NO ___ MIGRAINE HEADACHES	_____	YES ___ NO ___ KIDNEY DIS.	_____
YES ___ NO ___ CATARACTS	_____	YES ___ NO ___ LIVER DIS.	_____
YES ___ NO ___ GLAUCOMA	_____	YES ___ NO ___ STOMACH ULCERS	_____
YES ___ NO ___ OTHER EYE DISEASES	_____	YES ___ NO ___ ALCOHOL / TOBACCO USE	_____

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE? _____

YES ___ NO ___ DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE ABOVE DISEASES?
IF SO, WHICH? _____

YES ___ NO ___ HAVE YOU HAD ANY EYE SURGERY? IF SO, WHAT, WHEN AND BY WHOM? _____

YES ___ NO ___ DO YOU HAVE ANY ALLERGIES? IF SO, TO WHAT? _____

IF YOU WEAR GLASSES, WHEN WAS YOUR LAST CHANGE IN GLASSES? _____

WHEN WAS YOUR LAST EYE EXAMINATION? _____ BY WHOM? _____

WHAT SURGICAL OPERATIONS HAVE YOU HAD? _____

WHAT MEDICATIONS DO YOU TAKE, INCLUDING EYE DROPS? _____

PHARMACY: _____

NAME OF FAMILY PHYSICIAN: _____

LIFETIME AUTHORIZATION

Medicare or Insurance Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I authorize any holder of medical information about me to release to Brandon Eye Clinic and/or MEDIGAP/Supplemental insurance any information needed to determine these benefits or the benefits payable for related services and/or to aid in my medical care.

I request that this authorization also apply to any insurance other than Medicare. I also request that payment of authorized MEDIGAP/Supplemental benefits be made on my behalf to Brandon Eye Clinic for any services furnished me by physicians of Brandon Eye Clinic. I authorize any holder of medical information about me to release to Brandon Eye Clinic and/or MEDIGAP/Supplemental insurer any information needed to determine these benefits or the benefits payable for related services and/or to aid in my medical care.

INSURANCE DISCLAIMER: Due to the many different kinds of insurance companies, you are required to know your insurance coverage. Payment for all services rendered is your responsibility. This also applies to you if you choose to use an out of network physician at our facility under your HMO/PPO plan. I also, understand by signing, I am guaranteeing payment of this account (if insurance is billed and doesn't pay as well). Failure to pay on this account within 120 days will result in collections fees applied to this account balance, if any.

INFORMATION REGARDING DILATING EYE DROPS

DILATION IS THE STANDARD OF CARE TO ALLOW THOROUGH EVALUATION OF EYE TISSUE FOR A NUMBER OF EYE CONDITIONS. The use of dilation drops temporarily increases the size of your pupils, which allows an eye physician to more accurately investigate the health of your eyes. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected, and because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. For a short time, wearing sunglasses may be a necessary comfort. Adverse reactions, such as acute angle-closure glaucoma may also be triggered and/or diagnosed by the dilating drops. Call our office immediately if you experience excessive pain, discomfort, nausea, or any other untoward symptoms. Thank you for your assistance during this important procedure.

By signing this form I hereby acknowledge that I am aware of the above information and authorize my physicians and/or their assistants to administer dilating eye drops to assist in the optimum evaluation of my eyes. My acknowledgment and authorization shall be without expiration, but I am aware that (as all other diagnostic or treatment procedures) AT ANY TIME I MAY ELECT TO NOT HAVE THIS IMPORTANT PROCEDURE BY SIMPLY INFORMING THE TECHNICIAN AND/OR PHYSICIAN. If I elect to not use dilating drops for my examination, I also hereby affirm that I am aware that my decision may reduce the ability of my physician to optimally care for my eyes.

Signed by Patient (or person authorized to sign for patient)
Date _____

Medigap/Supplemental Signature:

By: Self or *
Relationship _____

Date _____
Witness _____

* If signed by other than beneficiary, state the reason patient was unable to sign: