Tucker Vision Center

88 Pine Island Road Suite 3 North Fort Myers, FL. 33903
Phone: 239-656-1778 Fax: 239-656-5858

Name: _____

Address: _____

Phone: _____

Email: _____

Date of Birth: _____

SSN: _____

Sex: Male or Female

Ocular History:

Purpose of today`s visit:

□ Annual Visit □ Headaches
□ Blurry Vision □ Infection
□ Burning □ Night vision difficulty
□ Double Vision □ Eye Pain
□ Dryness □ Tearing
□ Flash of light □ Update Contacts
□ Floaters □ Grittiness

When was your last eye exam? _____
Do you wear contact lenses ? Yes or NO

Have you been Diagnosed with the following ?

□ Cataracts □ Iritis/uveitis
□ Corneal abrasion □ Lazy Eye
□ Dry Eye □ Macular Degeneration
□ Eye Turn □ Retinal defect/hole/tear
□ Glaucoma □ Retinal detachment
□ Injury □ Other eye diseases

Has anyone is your **family** been diagnosed with the following?

□ Cataracts □ Lazy Eye
□Eye Turn □ Macular Degeneration
□Glaucoma □Retinal detachment
□Iritis/uveitis □Other eye disease

Visual Needs Assessment:

Hours of computer usage per day: _____
Hours of outdoor activity per day: _____
Hobbies: _____

Current Medications and Dose: _____

_____

_____

_____

Allergies: _____

_____

List any prior surgeries and dates if known: _____

_____

Any chance you can be pregnant? YES NO
Do you smoke use cigarettes? YES NO
Do you drink alcohol? YES NO

Medical History:

Have you ever been diagnosed or treated for any of the following health problems? (If yes circle yes and if no circle no, circle F for family history and list family member?

Allergies: YES NO F: _____
Arthritis: YES NO F: _____
Cancer: YES NO F: _____
Cholesterol: YES NO F: _____
Diabetes: YES NO F: _____
Heart Disease: YES NO F: _____
High Blood Pressure: YES NO F:_____
Headaches: YES NO F:_____
Kidney: YES NO F:_____
Muscle or Bone: YES NO F: _____
Sinus: YES NO F:_____
Stroke/Seizures: YES NO F: _____
Throat Infections: YES NO F:_____
Thyroid: YES NO F:_____

Who can we thank for your referral to our office?

_____

Pharmacy: _____

_____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice`s Notice of Privacy Practices written in plain language. The Notice providers in detail the uses and disclosures of my protected health information that may by this practice., my individual rights and the practice`s legal duties with respect to my protected health information. The Notice includes:

□ A statement that this practice is required by law to maintain the privacy of protected health information.

□ A statement that this practice is required to abide by the terms of the notice currently effect.

□Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations.

□ A description of uses and disclosures that are prohibited or materially limited by law.

□ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

□ A description of other users and disclosures that will be made only with my written authorization that I may revoke such as authorization.

□ I received notification that the members at Tucker Vision Center will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my constant can be revoked at any time. Revocation must be made in writing.

□ **My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to :**

o The right to complain to this practice and to the Secretary and Human Services (HHS) if I believe my privacy right have been violated and that no retaliatory actions will be used against me in the event of such a complaint. The right to receive confidential communications of protected health information. The right to amend protected health information. The right to inspect and copy protected health information.

o The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

Do you want a copy of the Notice of Privacy Practices? YES NO (MUST CIRCLE ONE)

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that remains. Please list any persons we are allowed to discuss your private information with or list no one.

_____ _____

_____ _____

Patient Name:_____ Patient Signature: _____

DATE: _____ Staff member witnessed initial: _____

Payment Policy:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, private insurance and any other health plans to Tucker Vision Center. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Tucker Vision Center within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. I understand that the interest of 18.5% every year is added on after opening balances after 30 days. I certify that my responses on this form are accurate to the best of my knowledge. ***I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacture warranty or office warranty programs.***

Signature: _____ Date:_____

Optomap Digital Eye Imaging Technology

Tucker Vision Center is please to offer you and your family the most highly advanced technology available in eye disease detection: the Optomap Digital Retinal Imaging System. Dr. Tucker is concerned about retinal disease such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy, all which can lead to partial loss of vision or blindness. Additionally, systemic disease such as diabetes and high blood pressure can be detected with retinal examination. Eye exams with retinal evaluations can help you safeguard both your eyesight and general health. The Optomap Digital Imaging System allows us to *scan 85% of the retina* to thoroughly evaluate your internal eye health with dramatically improved precision. With an annual Optomap, Dr. Tucker can track your eye health for concerns, perform annual comparisons and initiate treatments sooner. Most medical and vision insurance don't cover routine photos. As a result, there is a $39.00 fee for this procedure.

Dr. Tucker strongly recommends that all patients have this procedure performed annually. It is especially important for people who have :

Headaches
Diabetes
High Blood Pressure
High Cholesterol
Family History of glaucoma, blindness or macular degeneration
Family History of diabetes or high blood pressure

The OCT MAC SCAN is recommended annually to make sure the macula (centrally vision) is maintain healthy. It is like an MRI of the eye and it shows Dr. T layer by layer how healthy the macula is doing. Normal cost is 45.00 if you do it today it is $20.00 which will be collected the day of appointment.

Please Circle YES or NO

The Optomap Photo enhances a dilated exam by creating a permanent documentation of the retina. If you want to have the Optomap today please circle yes which means you will be charged $39.00 or if no please circle no.

YES **NO**

Patient Name: _____ Date:_____

Patient Signature: _____

Contact Lens Care Agreement:

Contact lenses are FDA class I medical devices that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of Florida State Board require an annual examination for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poof surface compatibility, in addition to any vision changes. The estimated fee for **new contact lenses wearers range between $175.00-$275.00** depending on type of contact lenses needed for that patient. The estimated fee for **established contact lenses wearer range between $100.00-$230.00** depending on type of contact lenses needed for that patient. **These fees will cover any contact lens related follow ups for a 30 day period. If you cannot complete the fitting procedure in 30 days time due to missed follow up appointments, you must repay contact fitting price.**

By signing, I knowledge that I understand the polices regarding the contact lens health evaluation and agree to associate fees. I understand that these fees are an estimate and are subject to changes based on doctor`s final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand that if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Patient Signature: _____ DATE: _____

CONTACT LENS QESTIONAIRE: Brand of Contacts Now: _____ Solution:_____

Vision:

Can you see distance and near comfortably with your contact?	Yes	No
Do you wear MONO vision one eye distance one eye near?	Yes	No

Life Style:

How many days a week do you wear your contacts?	_____
How many hours a day do you wear you contact?	_____

If you store your solution, do you discard your solution every morning?	Yes	No
Do you sleep overnight in your contacts?	Yes	No
□ If you sleep in your contacts, for how many nights in a row?	Yes	No
Do you swim in your contacts?	Yes	No
Do you shower in your contacts?	Yes	No

Comfort:

Do you experience dryness with your contacts?	Yes	No
Do you have difficultly with seasonal allergies?	Yes	No

Contact Lens History:

Have you had a contact lens related infection?	Yes	No
Is your wearing time for contacts decreased over the years?	Yes	No

Hygiene:

Do you have a backup pair of glasses?	Yes	No
How often do you change your contact lens case?	_____	

Please rank from most important to least important so that the doctor can prescribe to enhance your contact lens experience (1-MOST Important, 4 Least Important):

_____ Convenience _____ Comfort _____ Clarity _____ Cost