***Excellence in Eye Care, LLC Patient Information Form***

***Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_*

*Name of responsible party (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please circle: Parent / Guardian / Care-giver*

*Previous patient of Dr. Scamard? Yes No Prescription for? Glasses Contact Lens Date of last exam:\_\_\_\_\_\_\_\_\_\_*

*What is the reason for today's visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Please list any* ***eye*** *conditions you may have or past* ***eye******surgeries****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Please list any history of* ***eye******disease*** *that may exist in your* ***family****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Please list any* ***eye******medications*** *you are taking, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Please list any* ***medical*** *conditions you may have or any past* ***medical*** *surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Please list any* ***medications*** *you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Please list any* ***allergies******to medications*** *of which you are aware: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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***Disclosures:***

***Dilation:*** *The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a dilated fundus examination. This procedure involves the doctor instilling an eye drop in each eye that will dilate the pupils. With the pupils dilated, the doctor will be able to assess the health of the internal structures of the eyes. This is important for the diagnosis of any possible sight-threatening eye disease. The side effects of dilation include sensitivity to light and blurry near vision - which can last up to five hours or longer. Driving may be difficult and should be done with extreme caution.*

***I understand the importance of dilation and (please check one): I agree to have my eyes dilated today.***

***I do not wish to have my eyes dilated today - but will plan to have them dilated at another visit.***

***HIPPA Privacy (Acknowledgement of Receipt of Privacy Notice):*** *By signing this acknowledgement of Receipt of Notice of Privacy Practices, I hereby acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand this doctor's office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and / or type of products provided) to another party to permit this doctor's office to perform its administrative duties, provide me with eye care services and products and, if applicable, process my vision benefit claims and communicate with my insurance provider regarding vision care services provided by this doctor's office. This doctor's office is committed to the privacy of its patients and assures them that it does not sell personal health information of any kind to a third party for such party's own use. If applicable, I hereby authorize this doctor's office to submit my vision benefit claim to my plan sponsor or health plan to receive reimbursement directly for the vision services I have received from this doctor's office. If I am not utilizing insurance for today's visit, I understand I am responsible for payment of the services I receive from this doctor's office - which are due at time of service.*

***Signature of Patient or Patient's Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Physician's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Dr. David F. Scamard, O.D.***