

## PATIENT REGISTRATION AND CONSENT

Patient Name (Last, First, Middle Initial)			DOB / /	
Address		City	State	Zip
Home Phone ( )	Cell Phone ( )	Email (required for patient portal access)		
Social Security #	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Ethnicity	Race	Preferred Language
Emergency Contact				
Name		Relationship	Phone	
Primary Insurance				
Name	ID#	Subscriber Name	DOB	
Secondary Insurance				
Name	ID#	Subscriber Name	DOB	
<b>All non covered insurance items are patient responsibility</b>				
Preferred Pharmacy				
Name		Address	Phone	
Primary Care Physician (PCP)				
Name		Address	Phone	
Referring Doctor (Other than PCP)				
Name		Address	Phone	

### Patient Consent

- ☀ I have been provided a copy of the Notice of Patient Privacy Practices that provides a more complete description of Protected Health Information uses and disclosures.
- ☀ I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Perich Eye Center and its associated providers, clinicians and other personnel. I understand that no guarantee has been or can be made as to the results.
- ☀ I consent to the use and disclosure of my/the patient's Protected Health Information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Notice of Patient Privacy Practices.
- ☀ I authorize payment of medical benefits directly to Perich Eye Center or their designee for services rendered.
- ☀ I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
- ☀ If you receive a prescription from any Perich Eye Center location for eyeglasses/contacts and purchase online, **we have a NO REFUND POLICY** on all contacts, frames, eyeglass lenses, and complete pair of glasses.

Patient Name (print) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient / Authorized Person Signature \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Please select any of the following medical conditions that you currently have:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ANXIETY              | <input type="checkbox"/> ARTHRITIS               | <input type="checkbox"/> END STAGE RENAL DISEASE   |
| <input type="checkbox"/> DEPRESSION           | <input type="checkbox"/> ASTHMA                  | <input type="checkbox"/> HEPATITIS                 |
| <input type="checkbox"/> PSYCHIATRIC DISORDER | <input type="checkbox"/> COPD                    | <input type="checkbox"/> HIV/AIDS                  |
| <input type="checkbox"/> CLAUSTROPHOBIA       | <input type="checkbox"/> IRREGULAR HEARTBEAT     | <input type="checkbox"/> MRSA                      |
| <input type="checkbox"/> MEMORY LOSS          | <input type="checkbox"/> CORONARY ARTERY DISEASE | <input type="checkbox"/> HYPERTHYROIDISM           |
| <input type="checkbox"/> ALZHEIMER'S          | <input type="checkbox"/> HIGH BLOOD PRESSURE     | <input type="checkbox"/> HYPOTHYROIDISM            |
| <input type="checkbox"/> MIGRAINES            | <input type="checkbox"/> HEART ATTACK            | <input type="checkbox"/> ENLARGED PROSTATE         |
| <input type="checkbox"/> SEIZURES             | <input type="checkbox"/> HIGH CHOLESTEROL        | <input type="checkbox"/> CANCER; Which Kind: _____ |
| <input type="checkbox"/> STROKE               | <input type="checkbox"/> DIABETES                |  |
| <input type="checkbox"/> HEARING LOSS         | <input type="checkbox"/> GERD                    | <input type="checkbox"/> RADIATION / CHEMO         |
| <input type="checkbox"/> OTHER _____          |  |  |

Have you had any surgeries within the past 4 years? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### OCULAR HISTORY / OR CURRENTLY EXPERIENCING

- |  |       |       |  |       |       |
|--|-------|-------|--|-------|-------|
| <input type="checkbox"/> CATARACTS:            | R Eye | L Eye | <input type="checkbox"/> BLEPHARITIS:        | R Eye | L Eye |
| <input type="checkbox"/> GLAUCOMA:             | R Eye | L Eye | <input type="checkbox"/> OPHTHALMIC MIGRAINE | R Eye | L Eye |
| <input type="checkbox"/> MACULAR DEGENERATION: | R Eye | L Eye | <input type="checkbox"/> DRY EYE SYNDROME    |       |       |
| <input type="checkbox"/> RETINAL DETACHMENT    | R Eye | L Eye | <input type="checkbox"/> GLASSES Prism       |       |       |
| <input type="checkbox"/> VITREOUS FLOATERS     | R Eye | L Eye | <input type="checkbox"/> CONTACTS: Hard Soft |       |       |
| <input type="checkbox"/> FLASHES OF LIGHT:     | R Eye | L Eye | <input type="checkbox"/> OTHER _____         |       |       |

### OCULAR PROCEDURES / SURGERIES

- |  |       |       |   |       |       |
|--|-------|-------|---|-------|-------|
| <input type="checkbox"/> CATARACT SURGERY:   | R Eye | L Eye | <input type="checkbox"/> GLAUCOMA SURGERY:        | R Eye | L Eye |
| <input type="checkbox"/> YAG CAPSULOTOMY     | R Eye | L Eye | <input type="checkbox"/> GLAUCOMA LASER:          | R Eye | L Eye |
| <input type="checkbox"/> LASIK SURGERY:      | R Eye | L Eye | <input type="checkbox"/> INTRAVITREAL INJECTIONS: | R Eye | L Eye |
| <input type="checkbox"/> RETINAL DETACHMENT: | R Eye | L Eye | <input type="checkbox"/> EYE MUSCLE SURGERY:      | R Eye | L Eye |
| <input type="checkbox"/> RETINAL LASER:      | R Eye | L Eye | <input type="checkbox"/> LID SURGERY:             | R Eye | L Eye |
| <input type="checkbox"/> CORNEAL TRANSPLANT: | R Eye | L Eye | <input type="checkbox"/> PUNCTAL PLUGS:           | R Eye | L Eye |

I approve to have my pharmacy history imported.

Patient Signature \_\_\_\_\_

**\*Please list below all of your prescribed medications, ocular medications and over the counter medications you take (including vitamins); or if you have a list we will make a copy\***

NAME OF MEDICATION	DOSAGE	FREQUENCY

Do you have a **SENSITIVITY** to **LATEX**?  
YES NO

Are you **SENSITIVE** to **ADHESIVE TAPE**?  
YES NO

**LIST OF ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke?     YES     NO     FORMER    How much per day? \_\_\_\_\_

Do you drink alcohol?  YES     NO     FORMER    How much per day? \_\_\_\_\_

**FAMILY HISTORY**

Please indicate (✓) which family members have / had the following diseases:

Condition	Father	Mother	Brother	Sister
Blindness				
Cancer				
Diabetes				
Glaucoma				
High Blood Pressure				
Macular Degeneration				
Stroke				
Thyroid Disease				

**MEDICAL INFORMATION RELEASE FORM**

**(HIPAA RELEASE FORM)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages**

Please call  my home  my work  my cell phone: \_\_\_\_\_

If unable to reach me:

You may leave a detailed message.

Please leave a message asking me to return your call.

\_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## DILATION CONSENT & NOTIFICATION FORM

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate pupils of your eyes. This will require placing drops in your eyes that will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision. In most cases the distance vision will be minimally affected. In some instances you may experience blurred distance vision following your exam, our office recommends that you have someone to assist you with driving after your appointment. As a precaution, you were advised, when you scheduled your appointment, you had the option to bring a driver with you. The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may wish to omit this procedure. **Please indicate your preference below:**

\_\_\_\_\_ **I have read and understood the above stated information and I choose to be dilated.**

\_\_\_\_\_ **I do not wish to be dilated and I understood that certain pathologies may not be detected as a result.**

**Patient's Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## **Cancellation / No Show Policy For Doctor Appointments**

### *Cancellation / No Show Policy*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment and appointments are in high demand.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

**If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar (\$25) fee; this will not be covered by your insurance company and will be payable upon your next visit.**

### *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

**If a patient is 20 minutes past their scheduled time we may have to reschedule the appointment.**

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**Patient Name (Print)**

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**Patient Signature**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Date**

Patient Account # \_\_\_\_\_  
(Office Use Only)

*Perich Eye Centers of New Port Richey \* Spring Hill \* Tampa  
The Eye Institutes of The Villages \* Wesley Chapel \* Zephyrhills*

**Perich Eye Center**  
**Photograph & Video Release Form**  
**Consent to Obtain Patient Feedback**

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recording along with written testimony done on my behalf based off of verbal comments made by me to staff of the above mentioned company may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos
- marketing purposes
- use on websites

By signing this release I understand this permission signifies that written testimony, photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to self-written writings or writings done on my behalf by said company, photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

In addition, it was a pleasure to provide you with professional eye care services today. It is our goal to always meet or exceed your service expectations. In an effort to always reach this goal, patient feedback is critical. With this being said, we would like to request the opportunity to contact your via e-mail or phone to obtain your feedback regarding todays visit. Our office staff appreciates your honesty, loyalty and business.

In addition to the above, by checking the box I extend Perich Eye Center my consent to contact me for purpose of providing feedback about my experience with Perich Eye Center.

Full Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_