

WELCOME!



Professional Attentive Eye Care Excellence.

1 Patient Information

Patient Name _____
 Street Address _____
 Apt. # _____
 City/State/Zip _____
 Home Phone (____) _____
 Work Phone (____) _____
 Cell Phone (____) _____
Best Time & Place to Call _____
E-mail Address _____
 Sex: M F Age _____ Birthdate _____
 Occupation _____
Would it be OK to send reminders by text? Yes No
Whom may we thank for referring you to us? _____
 Friend/Relative/Spouse _____ Dr. _____
 Internet _____ Website _____ Social Media _____

2 Benefit Plan Information

Vision Benefit Plan _____
 Member / Policy # _____ Group # _____
 If covered by spouse, Name _____
 SSN (last 4 digits) - _____ DOB _____
Medical Plan _____
 Member / Policy # _____ Group # _____
Employer _____
IF PATIENT IS DEPENDENT OR CHILD COMPLETE BELOW
 Responsible Person _____
 Relationship to Patient _____
 Address _____
 City/State/Zip _____
 Home Phone (____) _____
 Cell Phone (____) _____
PRIMARY CARE PHYSICIAN-Dr. _____

3 Eye Health History

<p>Last Eye Exam ____ / ____ / ____ Last Eye Doctor _____ Do You Wear Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No & Polarized Sunglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Do You Wear Contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No What Kind? ___ Daily ___ Overnight ___ Soft ___ Toric ___ Multifocal Interested <i>NEW BREAK- THROUGH COLORS</i> Contacts? Yes ___ No ___ (available with or without vision correction) ADVANCED VISION OPTIONS: Correction beyond Glasses, such as LASIK or Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Do You Experience Computer/ Tablet/Cell Eyestrain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Hobbies: <input type="checkbox"/> Golf <input type="checkbox"/> Tennis <input type="checkbox"/> Boating <input type="checkbox"/> Fishing <input type="checkbox"/> Hiking <input type="checkbox"/> Bicycling <input type="checkbox"/> School Sports <input type="checkbox"/> Fitness <input type="checkbox"/> Other Interests _____ _____ _____</p>	<p>Please check the box below to indicate if you have any of the following: (with correction if worn)</p> <table border="0"> <tr> <td>Blurred Vision – Distance</td> <td><input type="checkbox"/> Yes</td> <td>Glaucoma</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Blurred Vision – Near</td> <td><input type="checkbox"/> Yes</td> <td>Headaches.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Burning Eyes</td> <td><input type="checkbox"/> Yes</td> <td>Itching Eyes.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Cataracts</td> <td><input type="checkbox"/> Yes</td> <td>Light Sensitive.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Color Vision – Poor.....</td> <td><input type="checkbox"/> Yes</td> <td>Loss of Vision</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Crossed Eyes</td> <td><input type="checkbox"/> Yes</td> <td>Eye Pain</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Discharge From Eyes</td> <td><input type="checkbox"/> Yes</td> <td>Night Vision – Poor.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Double Vision.....</td> <td><input type="checkbox"/> Yes</td> <td>Red Eyes.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Dry Eyes/Gritty</td> <td><input type="checkbox"/> Yes</td> <td>Seeing Halos.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Eye Infection</td> <td><input type="checkbox"/> Yes</td> <td>Seeing Flashes</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Eye Injury</td> <td><input type="checkbox"/> Yes</td> <td>Temporary Loss of Vision....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Eye Strain</td> <td><input type="checkbox"/> Yes</td> <td>Twitching Eyelid</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Fainting Spells/Blackouts</td> <td><input type="checkbox"/> Yes</td> <td>Vision – Poor.....</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Floaters or Spots</td> <td><input type="checkbox"/> Yes</td> <td>Watering Eyes</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Glare.....</td> <td><input type="checkbox"/> Yes</td> <td></td> <td></td> </tr> </table> <p>IF CHILD: Doesn't enjoy reading.....<input type="checkbox"/> Yes Homework takes longer.....<input type="checkbox"/> Yes Poor writing skills.....<input type="checkbox"/> Yes Short attention span.....<input type="checkbox"/> Yes</p>	Blurred Vision – Distance	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes	Blurred Vision – Near	<input type="checkbox"/> Yes	Headaches.....	<input type="checkbox"/> Yes	Burning Eyes	<input type="checkbox"/> Yes	Itching Eyes.....	<input type="checkbox"/> Yes	Cataracts	<input type="checkbox"/> Yes	Light Sensitive.....	<input type="checkbox"/> Yes	Color Vision – Poor.....	<input type="checkbox"/> Yes	Loss of Vision	<input type="checkbox"/> Yes	Crossed Eyes	<input type="checkbox"/> Yes	Eye Pain	<input type="checkbox"/> Yes	Discharge From Eyes	<input type="checkbox"/> Yes	Night Vision – Poor.....	<input type="checkbox"/> Yes	Double Vision.....	<input type="checkbox"/> Yes	Red Eyes.....	<input type="checkbox"/> Yes	Dry Eyes/Gritty	<input type="checkbox"/> Yes	Seeing Halos.....	<input type="checkbox"/> Yes	Eye Infection	<input type="checkbox"/> Yes	Seeing Flashes	<input type="checkbox"/> Yes	Eye Injury	<input type="checkbox"/> Yes	Temporary Loss of Vision....	<input type="checkbox"/> Yes	Eye Strain	<input type="checkbox"/> Yes	Twitching Eyelid	<input type="checkbox"/> Yes	Fainting Spells/Blackouts	<input type="checkbox"/> Yes	Vision – Poor.....	<input type="checkbox"/> Yes	Floaters or Spots	<input type="checkbox"/> Yes	Watering Eyes	<input type="checkbox"/> Yes	Glare.....	<input type="checkbox"/> Yes		
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4 Medications

Please list **all** medications you are currently taking, including eye drops, and **for what medical reason:** IF NONE (circle)

5 Allergies

Are you allergic to **any** medications? Yes No
 If yes, please list: _____

NOTE: If you have a printed list of current medications/
 allergies, please provide to front desk so a copy can be made.

6

Medical Health History

PLEASE CHECK THE BOXES BELOW TO INDICATE **IF YOU** HAVE CURRENTLY OR HAVE A HISTORY OF ANY OF THE FOLLOWING:

ALSO CHECK THE BOX TO INDICATE IF A BLOOD RELATIVE HAS A HISTORY OF ANY THE FOLLOWING:

PLEASE NOTE: PROVIDING INCOMPLETE OR INCORRECT INFORMATION CAN BE DETRIMENTAL TO YOUR HEALTH.

	<u>Yourself</u>	<u>Relative</u>		<u>Yourself</u>	<u>Relative</u>
AIDS/HIV	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Heart Valve.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Joints.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Macular Degeneration.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bleeding	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Blindness.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cataracts.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Rheumatic Disease/Fever.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Chemical Dependency.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Shingles.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cold Sores/Fever Blisters.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes
Diabetes.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Skin Conditions.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Drug Sensitivity	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Emphysema / COPD	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Epilepsy.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Tuberculosis.....	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Eye Surgery.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Other _____		
Glaucoma	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes			
Hay Fever	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Number of children: _____		
Hepatitis (type _____).....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Tobacco Use <input type="checkbox"/> No <input type="checkbox"/> Occasional..... <input type="checkbox"/> Frequent		
High Blood Pressure.....	<input type="checkbox"/> Yes.....	<input type="checkbox"/> Yes	Alcohol Use <input type="checkbox"/> No <input type="checkbox"/> Occasional..... <input type="checkbox"/> Frequent		

7

Expectations/Reason(s) For Today's Visit: _____

8

Authorization

I hereby certify that I have read, understood and answered the above questions accurately to the best of my knowledge. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent in order for any third party payor to pay directly to **FLORIDA EYE DOCTORS or to Dr. Salvatore DeCanio**, any insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges, whether or not paid by my insurance carrier or vision benefit plan, rendered on my behalf or my dependents. I agree to pay a minimum collection fee of \$30.00 and any applicable collection costs and/or attorneys' fees if I do not satisfy payment for services rendered. I authorize the use of this signature on all insurance and/or benefit plan submissions made in my behalf.

X _____
Signature of Patient or Responsible Person

Relationship to Patient if Dependent or Minor Child

_____/_____/_____
Date

9

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option you prefer :

- Cash Debit AMEX
- Visa MasterCard Discover

Payment in full is due today for any and all professional fees and/or applicable products. SORRY WE CANNOT ACCEPT CHECKS

Thank You!

FLORIDA EYE DOCTORS - Dr. DeCanio & Associates would like to take this opportunity to thank you for trusting us as your eye care professionals. As we believe that **CLEAR VISION BEGINS WITH HEALTHY EYES**, a lifetime of preserving your precious eyesight is our primary concern.

We Welcome New Patients & Appreciate Your Kind Referrals!