EyeSite
2909 Traverse Trail
The Villages, Florida 32163
352.674.EYES

WELCOME TO OUR PRACTICE!

Name:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ E-Mail:_____

Home:(____)_____ Work:(____)_____ Cell:(____)_____

Birth Date:_____ Sex: M F Employer:_____ Occupation:_____

Medical insurance:_____ 2nd Insurance:_____

Primary Insured Name & DOB:_____

Emergency contact:_____ Ph:(____)_____

Primary Care Provider:_____ Ph:(____)_____

What hobbies do you enjoy?_____

How did you hear about our office? ☐Referral ☐ Ad ☐Walk-by ☐ Internet ☐ Insurance ☐Other

Do you have eyestrain from computers? Y N Do you own prescription sunglasses? Y N

Medical Questionnaire:

Do you have any of the following? Y/N		Family Member?/Relation Y/N	
○ ○	High Blood Pressure	○ ○	_____
○ ○	Heart Disease	○ ○	_____
○ ○	Diabetes (Since:_____)	○ ⊙	_____
○ ○	Thyroid Problems	⊙ ○	_____
○ ○	Headaches/Migraines	⊙ ○	_____
○ ○	Arthritis	○ ⊙	_____
○ ○	Pulmonary Disease	○ ○	_____
○ ○	High Cholesterol	○ ○	_____
○ ○	Cancer	○ ○	_____
○ ○	HIV or Hepatitis	○ ○	_____
○ ○	Glaucoma	○ ○	_____
○ ○	Cataracts	○ ○	_____
○ ○	Macular Degeneration	○ ○	_____
○ ○	Retinal Detachment	○ ○	_____
○ ○	Eye Surgery	○ ○	_____
○ ○	Vision Loss/Blindness	○ ○	_____
○ ○	Visual Spots	**List any eye surgeries:**	
○ ⊙	Flashing Lights	_____	
○ ○	Other_____	_____	
○ ○	Are you pregnant?	_____	
○ ○	Are you nursing?	_____	

List Your Medications:

_____

_____

_____

_____

_____

_____

_____

_____

List Your Allergies:

_____

_____

_____

_____

_____

Social History:

Tobacco? Y ○ N ⊙

Alcohol? Y ⊙ N ○

Drugs use? Y ○ N ⊙

Reason for Visit:_____

EyeSite
2909 Traverse Trail
The Villages, Florida 32163
352.674.EYES

Pupillary Dilation

Florida law requires all Board Certified Optometric Physicians to include pupillary dilation as a part of a **NEW** Comprehensive Eye Exam. After the dilated examination, you may experience blurred vision and light sensitivity for approximately four (4) to six (6) hours. This could possibly impact your ability to drive or perform certain visual tasks. Pupillary dilation is an important component of an eye exam because it enables the physician to better evaluate the health inside your eyes. Without it, it is possible to overlook potential vision or life-threatening conditions. Please check which option below best suits your schedule:

_____I would like to have my eyes dilated today.

_____I would like to reschedule the dilated portion of my exam to another day. (An out-of-pocket office visit fee will apply to this visit)

_____I do not want my eyes dilated.

Signature:_____Date:_____

Printed Name:_____

Retinal Imaging

The Optovue **iWellness** health assessment and imaging system (The first of its kind in The Villages) allows our doctor to detect and manage disease more effectively and to monitor changes to your eyes over time. This **State-of-the-Art** technology works like an MRI or a CT scan, allowing a deeper view of the structure of your eyes and assists in the early detection of **macular degeneration, glaucoma, diabetes, and hypertension**. It is now the standard of care at **EyeSite of The Villages** to perform the **iWellness** examination at every comprehensive visit to detect any changes to your eyes from year to year.

_____ I accept this standard of care for $39 (not yet covered by medical insurance)

_____ I decline but understand the importance of the iWellness exam

EyeSite
2909 Traverse Trail
The Villages, Florida 32163
352.674.EYES

LIFETIME PATIENT CONSENT FORM

I understand that under ***The Health Insurance Portability & Accountability Act of 1996*** (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **NOTICE OF PRIVACY PRACTICES** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. This form is valid until your personal revocation.

Please list family/friends that may have access to your medical information below:

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Patient Name: _____

Signature: _____ Date: _____

Relation to Patient (if minor): _____