Date:_____

Site to See Patient Intake Form

Name: _____ **Date of Birth:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____ **Occupation:** _____

Welcome to our office! Please note that if you are using insurance, routine vision exams and medical eye visits are different and are covered under different insurance plans. The reason for the visit and the results of the examination determine whether insurance companies will classify the exam as “routine” or “medical” in nature, and as a courtesy we will bill your plan for today’s visit accordingly. These classifications are set by the insurance companies, not our practice, and we must comply with these guidelines. Vision insurance covers glasses or contact lens RX only, and no medical treatment is included. Any symptoms or concerns about conditions such as Diabetes, Glaucoma, Cataracts, Dry eyes, and Macular Degeneration are medical in nature and may require your medical insurance in order to be addressed.

Vision Insurance	**Medical Insurance**
Insured’s Name:_____	Insured’s Name:_____
DOB:_____ Relationship: _____	DOB:_____ Relationship: _____
Insured’s SS#:_____	Insured’s SS#:_____
Ins Company:_____	Ins Company:_____
Ins Phone #_____Employer _____	Ins Phone #_____Employer _____
ID/Member #:_____ Group #_____	ID/Member #:_____ Group #_____

Although optometrists primarily treat the eyes, health problems that you may have, or medications that you are prescribed, could have an important interrelationship with the eye examination you will receive. Thank you for answering the following confidential questions.

Purpose of today’s visit:

- ∘ Blurry vision
- ∘ Burning
- ∘ Double vision
- ∘ Dryness/Grittiness
- ∘ Flashes of light
- ∘ Floaters/spots in vision
- ∘ Headaches
- ∘ Infection
- ∘ Itchiness/Allergy
- ∘ Eye pain
- ∘ Redness
- ∘ Tearing
- ∘ Update contact lenses
- ∘ DMV Vision Form
- ∘ Other: _____

Ocular History:

When was your last eye exam?_____ Do you wear contacts? N / Y ; brand_____

Have you or your family been diagnosed with the following? (Circle: S - self and F - family)

Cataracts	S	F	Glaucoma	S	F	Macular degeneration	S	F
Dry Eye	S	F	Eye injury	S	F	Retina hole/tear/detachment	S	F
Eye turn/lazy eye	S	F	Iritis/Uveitis	S	F	Other eye disease:_____	S	F

List any medications you are currently taking:

_____

_____

List any medications you are allergic to:

_____

List any history of eye injuries or eye surgeries for yourself:

_____

Medical History:

Have you ever been diagnosed or treated for any of the following ? (Please specify condition in available space)

∘ Diabetes	∘ Autoimmune disorder	∘ Sleep apnea
∘ High blood pressure	∘ Thyroid	∘ Neurological
∘ Cholesterol	∘ Digestive / Gastric	∘ Psychological
∘ Arthritis	∘ Ear / Nose / Throat	∘ Respiratory
∘ Heart disease	∘ Stroke / Seizure	∘ Pregnant / nursing
∘ Cancer	∘ Skin condition	∘ Other: _____

Alcohol use ? ∘ none ∘ socially ∘ daily **Tobacco use?** ∘ none ∘ former ∘ smoker

Please provide the following information so that we may coordinate care with your physicians

Primary Care Physician: _____ Phone: _____ Fax: _____

Specialist: _____ Phone: _____ Fax: _____

(ex: Endocrinologist , Neurologist)

HIPAA PRIVACY (Acknowledgement of Receipt of Privacy Notice)

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I 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 that the Location 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 the Location to perform its administrative duties, provide me with eye care services and products, and process my vision or medical benefit claims. I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use.

I understand that Site to See may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, or treatment follow-up. Voice mail messages may contain specific appointment information. I understand that I must tell you if I do not want you to communicate with me like this. I allow Site to See to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

I have the right to request that the usage of my protected health information be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. I understand I have the right to withdraw this consent at any time, but I must do so in writing by contacting 13205 Reams Rd. Windermere, FL 34786.

Patient Signature or Patient's Legal Representative:

_____ Date: _____

How did you hear about us? _____ Who may we thank for referring you? _____

Patient Dilation Consent Form

Dilation is an important part of a complete eye exam. Performed at no additional charge. Dilation drops are used to enlarge the pupils. Useful in determining signs of systemic diseases such as diabetes, high blood pressure, cholesterol, cancer, etc. Can detect physical changes such as cataracts, glaucoma, retinal detachments, tumors, etc. that can affect your vision.

- Dilation side-effects: difficulty reading and light sensitivity- 4 or more hours

Driving is possible but should be done with extreme caution. If you do drive you're consenting to full responsibility for your own motor safety as well as others. **If you agree to dilation, you're also agreeing to not hold Raymond Forehand OD & Associates, LLC., liable for any accidents when operating a motor vehicle or otherwise.**

Helpful to have sunglasses to shield the eyes. If you feel uncomfortable driving, or have never driven while dilated, it is best to have someone drive you home.

- YES, dilation is okay if the doctor deems it necessary
- NO dilation. In declining, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test

Digital Eye Imaging Technology

Retina imaging is performed before every comprehensive eye exam. It allows the doctor to evaluate your internal eye structures with improved precision. Annual comparisons of your retina imaging helps track potentially site-threatening conditions. It is especially important if you have diabetes, high blood pressure, cholesterol, family history of glaucoma or macular degeneration, or suspicious lesions in the eye. $39 is applied to those using insurance but is included with self-pay exams. There are no side effects.

Payment Policy

- I hereby assign all vision and medical benefits to the optometric practice, Site to See. I hereby authorize said assignee to release all information necessary to secure payment. If my insurance company has not reimbursed Site to See within 60 days, I may be billed for any services or products that I have received.
- I understand that professional services rendered are non-refundable.
- I certify that I understand all eyeglasses are custom crafted for my eyes' unique prescription, and cancellations of an order may not be possible. Refunds or exchanges will be reviewed on a case-by-case basis, unless covered under manufacturer warranty or an office warranty program.
- I agree to pay all copays or out-of-pocket costs agreed upon prior to initiation of examination, treatment or manufacture of product

Patient Signature or Patient's Legal Representative:

_____ Date: _____

Print Name

_____

Signature