

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Tel: (\_\_\_\_\_)\_\_\_\_\_ Type: Home / Mobile

Email: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Sex: M / F Country of Origin: \_\_\_\_\_

Primary Doctor and Phone:  
\_\_\_\_\_

When was your last medical exam? \_\_\_\_\_

Are you experiencing any of the following?

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Red Eyes  | <input type="checkbox"/> Floaters/spots     |
| <input type="checkbox"/> Itching   | <input type="checkbox"/> Flashes of light   |
| <input type="checkbox"/> Burning   | <input type="checkbox"/> Eye pain           |
| <input type="checkbox"/> Tearing   | <input type="checkbox"/> Light Sensitivity  |
| <input type="checkbox"/> Sandiness | <input type="checkbox"/> Double Vision      |
| <input type="checkbox"/> Dry Eyes  | <input type="checkbox"/> Eye fatigue/strain |

When was your last eye exam? \_\_\_\_\_

Do you have seasonal allergies? Yes / No

Have you ever been diagnosed with the following?

- |   |   |
|---|---|
| Cataracts..... <input type="checkbox"/> Yes     | Glaucoma..... <input type="checkbox"/> Yes      |
| Macular   | Retinal   |
| Degeneration..... <input type="checkbox"/> Yes  | Detachment..... <input type="checkbox"/> Yes    |
| Strabismus..... <input type="checkbox"/> Yes    | Amblyopia..... <input type="checkbox"/> Yes     |
| Diabetes..... <input type="checkbox"/> Yes      | Stroke..... <input type="checkbox"/> Yes        |
| Blood Pressure.... <input type="checkbox"/> Yes | Heart Disease..... <input type="checkbox"/> Yes |
| Cholesterol..... <input type="checkbox"/> Yes   | Thyroid..... <input type="checkbox"/> Yes       |
| Asthma..... <input type="checkbox"/> Yes        | Sinusitis..... <input type="checkbox"/> Yes     |
| Rheumatoid                                      | Osteoporosis..... <input type="checkbox"/> Yes  |
| Arthritis..... <input type="checkbox"/> Yes     | Cancer..... <input type="checkbox"/> Yes        |
| Anemia..... <input type="checkbox"/> Yes        | Kidney Disease.... <input type="checkbox"/> Yes |
| Gastritis..... <input type="checkbox"/> Yes     | Multiple Sclerosis <input type="checkbox"/> Yes |
| Depression..... <input type="checkbox"/> Yes    | Rosacea..... <input type="checkbox"/> Yes       |
| Migraines..... <input type="checkbox"/> Yes     | HIV..... <input type="checkbox"/> Yes           |

Current Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Preferred Pharmacy and Phone:  
\_\_\_\_\_List prior surgeries(and dates) if any (e.g. LASIK)  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant or nursing? Yes / No

Do you smoke? Yes / No Cigs per day: \_\_\_\_\_

Do you drink? Yes / No Drinks per day: \_\_\_\_\_

Do you have any family members that attend this office? Please list their name and relationship:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a family relative that has/had any of the following? Please indicate family members.

Glaucoma.....☐ Yes Relation:\_\_\_\_\_

Macular

Degeneration.....☐ Yes Relation:\_\_\_\_\_Diabetes.....☐ Yes Relation:\_\_\_\_\_Blood Pressure..☐ Yes Relation:\_\_\_\_\_Cholesterol.....☐ Yes Relation:\_\_\_\_\_Stroke.....☐ Yes Relation:\_\_\_\_\_Heart Disease....☐ Yes Relation:\_\_\_\_\_Thyroid.....☐ Yes Relation:\_\_\_\_\_Cancer.....☐ Yes Relation:\_\_\_\_\_**Visual Needs Assessment:**

Occupation: \_\_\_\_\_

Do you wear contact lenses? Yes / No

Do you use sunglasses? Yes / No

Do you drive? Yes / No

Digital device usage per day : \_\_\_\_\_ hours

Sports/hobbies: \_\_\_\_\_

### **Notice of Privacy Practices Patient Acknowledgment**

Date: \_\_\_\_\_

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 the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that Ferrer Garcia Eyecare has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Guardian Name (if applicable): \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to patient (if signed by guardian): \_\_\_\_\_

### **No Show/Cancellation Policy:**

Ferrer Garcia Eyecare reserves the right to institute a formal policy regarding cancellations and "no shows". A "no show" is defined as a scheduled appointment that the patient fails to keep. All appointments require a credit card number in order to secure your appointment. Patients are expected to confirm their appointments via call, text, or e-mail. If we do not receive a confirmation 48 hours prior to your scheduled appointment time, **your appointment will be canceled.** A fee of **\$45** applies to a confirmed appointment that the patient fails to keep. **I certify that I understand that I am responsible for any fees charged according to this policy and I grant the office permission to store my credit card information.**

Signature: \_\_\_\_\_

### **Payment Policy:**

I hereby assign all medical benefits, including all major benefits to which I am entitled including Medicare, private insurance and any other health plans, to Ferrer Garcia Eyecare. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Ferrer Garcia Eyecare within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. **I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.**

Signature: \_\_\_\_\_

With patient consent, the office is allowed to retrieve your prescription history, if available, to reconcile your medications. To opt out, please let one of our staff members know.