YOUR EYE SPECIALISTS
POWERED BY AMERICAN VISION GROUP

NEW PATIENT FORMS

Completing your new patient forms in anticipation of your appointment will ensure a timely appointment and seamless process on the day of your visit with our specialists. **Please complete this packet prior to your visit.**

TWO CONVENIENT WAYS TO COMPLETE

PRINT and turn into our front desk staff on the date of your appointment

E-MAIL after completion to info@yeseyespecialists.com

Any questions prior to your visit, feel free to give us a call at 954-452-9922

AVENTURA
2801 NE 213 St, Suite 1006

PEMBROKE PINES
601 N Flamingo Rd, Suite 315

WESTON
2200 N. Commerce Pkwy, Suite 110

PLANTATION
1776 N. Pine Island Rd, Suite 214

JUPITER
550 Heritage Drive, Suite 105

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PATIENT INFORMATION

FIRST NAME | MIDDLE INITIAL | LAST NAME

SOCIAL SECURITY # | DATE OF BIRTH | AGE

☐ MALE ☐ FEMALE (SEX) | ☐ MARRIED ☐ SINGLE ☐ WIDOWED (MARITAL STATUS)

ADDRESS

CITY | STATE | ZIP CODE

OUT OF STATE ADDRESS (IF ANY)

CITY | STATE | ZIP CODE

HOME PHONE # | CELL PHONE #

EMPLOYER | OCCUPATION

WORK PHONE # | EMAIL ADDRESS

EMERGENCY CONTACT | RELATIONSHIP | EMERGENCY CONTACT PHONE #

PHARMACY AND REFERRALS

PHARMACY NAME, LOCATION & PHONE #

PRIMARY CARE PHYSICIAN'S NAME, LOCATION & PHONE #

REFERRING PHYSICIAN'S NAME, LOCATION & PHONE #

IF YOU WERE NOT REFERRED BY A PHYSICIAN, PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE

PRIMARY INSURANCE

POLICY HOLDER/SUBSCRIBER | DATE OF BIRTH | SOCIAL SECURITY # | POLICY/GROUP #

SECONDARY INSURANCE

POLICY HOLDER/SUBSCRIBER | DATE OF BIRTH | SOCIAL SECURITY # | POLICY/GROUP #

I am the above patient and attest this information is correct to the best of my knowledge.

SIGNATURE | DATE

REASON FOR VISIT?

PAST MEDICAL HISTORY (SELECT ALL THAT APPLY)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes HgA1c= _____
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Other _____
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

PAST SURGICAL HISTORY (SELECT ALL THAT APPLY)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Masectomy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Lumpectomy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Biopsy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement - Knee (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Joint Replacement - Hip (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Other _____
- ☐ Joint Kidney Replacement Within Last 2 Years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (☐ Right, ☐ Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

OCULAR HISTORY (SELECT ALL THAT APPLY)

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy, Background
- ☐ Diabetic Retinopathy, Proliferative
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Macular ERM
- ☐ Narrow Angles
- ☐ Ocular Hypertension
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear
- ☐ Strabismus
- ☐ PVD OD
- ☐ PVD OS
- ☐ Vitreous Floaters
- ☐ None
- ☐ Other _____

OCULAR SURGERY (SELECT ALL THAT APPLY)

- ☐ Blepharoplasty
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ DSAEK
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections
- ☐ LASIK
- ☐ LPI
- ☐ LTP
- ☐ PRK
- ☐ Ptosis Repair
- ☐ Punctal Plugs
- ☐ Strabismus Surgery
- ☐ Retinal Laser
- ☐ Trabeculectomy
- ☐ Tube Shunt
- ☐ Yag Capsulotomy
- ☐ Other _____
- ☐ None

MEDICATIONS

Please list all medications that you are currently taking including supplements:

DRUG	DOSAGE	FREQUENCY	DRUG	DOSAGE	FREQUENCY

ALLERGIES

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

ALLERGY	REACTION	SEVERITY

DILATION EYE DROPS

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the ophthalmologist to view the inside of the eye, the retina. Dilating drops cause blurred vision for 4 to 6 hours which may make bright lights bothersome. It is not possible for your ophthalmologist to know how much your vision will be affected. Because driving may be difficult, you may want to plan for a ride.

RELEASE OF INFORMATION

I hereby authorize Your Eye Specialists to release information acquired during my examination to my insurance company or employer for Workman's Compensation.

ACKNOWLEDGMENT

I acknowledge that the privacy practices of this office are available upon my request. I attest that I have read and understand the Patient Registration form and any questions have been answered.

REFRACTION POLICY

Refraction is a very important part of your eye exam. If you are experiencing blurred vision or a decrease in visual acuity on the eye chart, refractions are performed for the following reasons:

Diagnostic Test: to determine the best possible visual acuity and function of your eyes and diagnose if there are any medical problems with your eyes.

Prescription for Glasses: to determine whether you can be helped in any way by a new glasses prescription either before or after any eye surgery.

Note: Medicare and most medical insurance plans DO NOT cover it. If you have a separate vision plan that covers refraction, please let us know.

PRINT PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____

HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

NAME _____ RELATIONSHIP _____

CONTACT INFORMATION _____

Health Information to be disclosed upon the request of the person named above (Check either A or B)

- ☐ **A. Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)
- ☐ **B. Disclose** my health record, as above, BUT do not disclose the following (check as appropriate):
  - ☐ **Mental Health Records**
  - ☐ **Communicable Diseases (Including HIV and AIDS)**
  - ☐ **Alcohol/Drug Abuse Treatment**
  - ☐ **Other (Please Specify):** _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check One):

- ☐ All past, present, and future periods
- ☐ OR Date or Event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

NAME OF THE INDIVIDUAL GIVING THIS AUTHORIZATION _____ DATE OF BIRTH _____

SIGNATURE OF THE INDIVIDUAL GIVING THIS AUTHORIZATION _____ DATE _____

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

PATIENT'S NAME (PRINT)

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to **Your Eye Specialists** for services furnished me by **Your Eye Specialists**. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Your Eye Specialists** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Your Eye Specialists**, if possible or otherwise to me.

3. RELEASE OF INFORMATION: **Your Eye Specialists** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to **Your Eye Specialists** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Your Eye Specialists** may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that **Your Eye Specialists** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that **Your Eye Specialists** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **Your Eye Specialists** if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that **Your Eye Specialists's** contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **Your Eye Specialists** to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by **Your Eye Specialists**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Your Eye Specialists** for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to **Your Eye Specialists**. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Your Eye Specialists**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

PATIENT SIGNATURE OR AUTHORIZED PAY

DATE