Palm Beach Eye Clinic

First Name:_____ Middle Initial: _____ Last Name: _____

Please Circle: Male or Female **Social Security Number: _____**

Primary Language: _____ **Race: _____**

Date of Birth: _____ **Age: _____**

Ethnicity: □ Non Hispanic □ Hispanic or Latino □ Refused to Report

Address: _____

City: _____ State: _____ Zip Code: _____

Other Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Home: _____ Other:_____

Email Address: _____

Pharmacy Name: _____ Phone Number: _____

Location of Pharmacy: _____

Primary Doctor Name: _____ Number: _____

Emergency Contact Name: _____ Number: _____

Referred by Doctor: _____ Number: _____

INSURANCE INFORMATION Policyholder/Parental Information

Primary Insurance Company: _____

Secondary Insurance Company:_____

Name: _____

Date of Birth: _____ **SS#: _____**

Relationship to insured: _____ Phone Number: _____

X_____

Patient or Authorized to sign for Patient Signature Date

Palm Beach Eye Clinic

MEDICAL HISTORY

1. For what reason are you seeing the doctor? _____

_____

2. Have you ever had any serious eye disease or operations? **Y or N**
If yes please list and give approximate dates: _____

Have you had any severe eye injuries or eye infections: Y or N

_____

3. Do you have a family history of:
   a. Glaucoma **Y or N**
   b. Diabetes **Y or N**
   c. Macular Degeneration **Y or N**
   d. Retinal Detachments **Y or N**

4. Have you had or been diagnosed with:
   a. Heart attack or serious heart trouble **Y or N**
   b. Lung trouble **Y or N**
   c. Stroke **Y or N**
   d. Diabetes **Y or N**
   e. High Blood Pressure / Hypertension **Y or N**
   f. As being immuno-compromised **Y or N**
   g. High Cholesterol **Y or N**
   h. Low Cholesterol **Y or N**
   i. Hypotension **Y or N**

5. Have you ever smoked **Y or N** Please Circle: **Current or Former** If so, how many packs a day? _____

6. Alcohol use: **None Social Moderate Excessive**

7. Substance use: **None Social Moderate Excessive**

8. List all of your medications, eye drops, and vitamins with the dosage and frequency:

_____

_____

_____

_____

9. List your allergies or sensitivities and reactions to medications: _____

_____

10. List **other** major operations which you have had:

_____

_____

_____

11. I have made provisions for a living will and/or advance directives **Y or N**

Palm Beach Eye Clinic

I hereby authorize payment of insurance benefits directly to Andre J. Golino M.D. and Assoc., P.A., Nunzio Sossi M.D., Joseph Nezgoda M.D., and or Palm Beach Eye Clinic. I hereby authorize any holder of medical or other information about me to release the same to the Health Care Financing Administration, its related agencies, or my private insurer.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. (Sunglasses are very helpful) It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Dr. Nunzio Sossi, Dr. Joseph Nezgoda, and or his technicians to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

If my insurance denies payment or if my insurance *does not cover* my care at Palm Beach Eye Clinic I agree to pay personally for all services rendered. I acknowledge that it is my responsibility to know my insurance coverage and inform Palm Beach Eye Clinic of changes in my coverage.

Non-Covered services: I understand that certain services including **REFRACTIONS** (determination of prescription for eyeglasses and contact lenses) are a non-covered service and payment will be due on **date of service**.

Covered Services: I understand that all insurances, Medicare, PPOs and HMOs have a deductible and co-payment, which they do not cover. These deductibles and co-payments are my direct responsibility and I will pay for these at the time of services are rendered.

I hereby acknowledge that I have been presented with a copy of Palm Beach Eye Clinic's *"Notice of Privacy Practices".*

Refills and Messages: If you need a refill on your prescriptions you will be transferred to the Tech station and asked to leave a message. Messages left after 12:00 will be handle the next business day. To ensure you don't run out of your medications we suggest calling 3 days prior to your last dose.

Hours of Operation: A physician is available 24 hours per day, 7 days per week to address ***URGENT*** patient needs for established patients of Palm Beach Eye Clinic. If you feel you must speak to a physician and cannot wait to contact the physician during normal business hours, which are Monday, Tuesday, Wednesday, Friday 8:30 a.m. to 4:00 p.m. and Thursdays 8:30-3:00, then you may reach the physician on-call by calling our main office number at 561-832-6113. Our on-hold message will instruct you on how to be transferred to the on-call physician. The on-call physician will respond to the patients call within 30 minutes**.** If you are experiencing a medical emergency, please call 911.

I give permission to Palm Beach Eye Clinic to release my medical information to the following:

Name_____
Telephone number _____
Relationship_____

Name_____
Telephone number _____
Relationship_____

I have read and received all of the above policies.

X_____

Patient or Authorized to sign for Patient Signature Date